NHS Standard Contract 2022/23

Technical Guidance

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Executive Summary

1 Introduction

1.1 The NHS Standard Contract is published by NHS England, and its use is mandated for use by Clinical Commissioning Groups / Integrated Care Boards (CCGs/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, but a separate User Guide for the shorter-form version is also available. Guidance on when the shorter-form version should be used is set out in paragraph 9 below.

2 The 2022/23 Contract

2.1 The updated Contract is intended to set national terms and conditions applicable for the 2022/23 financial year. As always, if urgent issues arise during 2022/23 which require any amendment to the Contract, NHS England will consult on material changes and publish revised terms and conditions. (The delivery plan for tackling the COVID-19 backlog of elective care indicates that a consultation on revised access standards for cancer services is imminent, for example, and this may require in-year changes to the Contract to be considered.)

2.2 In 2020/21 and 2021/22, when the annual contracting round coincided with peak periods of the pandemic, the requirement for signed contracts with NHS Trusts and NHS Foundation Trusts was relaxed. But, as the NHS reverts to more normal working arrangements, it is important, from a governance perspective, that properly documented contracts are put in place in all cases. **Our expectation is therefore that written, signed contracts must be in place, for the full 2022/23 financial year, between commissioners and all providers (that is, with both Trusts and non-NHS providers).**

2.3 Subject to the passage of the Health and Care Bill through Parliament, and the necessary establishment orders being made once Bill is passed, CCGs will cease to exist and ICBs will come into being on 1 July 2022. Contracts should therefore be negotiated and signed, formally, by CCGs; signed contracts will then transfer from CCGs to ICBs under the nationally arranged Transfer Schemes provided for in the Bill. Guidance on these Transfer Schemes (Due diligence, transfer of people and property from CCGs to ICBs and CCG close down) is available on Future NHS. There will be no need for CCGs/ICBs to arrange novation of contracts, from CCG to ICB, at local level.

2.4 As currently, 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.

2.5 In most instances, commissioners and providers will be signing new contracts for 2022/23. Not all local contracts will expire at 31 March 2022, however. Alongside the final 2022/23 Contract, NHS England will therefore publish a National Variation, which commissioners and providers must implement to their non-expiring contracts, to ensure that these continue to reflect up-to-date national requirements. (For future years, the change we propose to make in relation to the online presentation of the Service Conditions and General Conditions of the Contract – described in paragraphs 3.19-23 below – will mean that National Variations will no longer be necessary.)

2.6 As described at https://www.england.nhs.uk/publication/2022-23-tariff-consultation/, a further consultation has now been launched in relation to the National Tariff Payment System for 2022/23. This specifically addresses the issue of the variable rate to be payable under the Aligned Payment and Incentives (API) Rules and to the arrangements for payment of activity carried out under sub-contracts. The Contract cross-refers at a high level to the provisions of the Tariff, but does not quote the specific variable rate as a percentage or refer directly to payment under sub-contracts. We have therefore seen no need to delay publication of the final Contract until completion of the second Tariff consultation. Once confirmed following the second consultation, the final approved variable rate will automatically take effect in the relevant local contracts.

2.7 The main changes made to the Contract for 2022/23 are summarised in section 3 below.

3 Proposed changes to Contract content

Adapting the Contract to reflect the Health and Care Bill

3.1 Publishing the Contract at this point – when the Parliamentary process to progress the Health and Care Bill is well advanced, but when the Bill has not yet received Royal Assent – poses some challenges. The Bill provides for the abolition of some organisations and concepts to which the Contract refers, for instance, and establishes new ones. This is true in respect of

- the abolition of Clinical Commissioning Groups (CCGs) and the establishment of ICBs;
- the abolition of Monitor and of the NHS Trust Development Authority, with their relevant functions being assumed by NHE England;
- the abolition of the Healthcare Safety Investigation Branch and the establishment of the Health Services Safety Investigations Body;
- the abolition of Local Education and Training Boards;
- the replacement of the National Tariff Payment System by the NHS Payment Scheme;
- the replacement of the current rules governing procurement of NHS-funded healthcare services (the Procurement, Patient Choice and Competition Regulations and the Public Contracts Regulations) by a new NHS Provider Selection Regime (see DHSC consultation here) ; and
- changes to the scope of the NHS Provider Licence, meaning that the Contract concept of "Essential Services", currently applicable only to NHS Trusts, will no

longer be needed, as NHS Trusts will come within scope of the Commissioner Requested Services regime within the Licence provisions.

3.2 Clearly, NHS England must not, in publishing the draft Contract, seek to pre-empt the will of Parliament by making assumptions about whether, to what extent and when the Bill will be enacted and/or the relevant provisions will come into effect. We have therefore sought, at this stage, to "future-proof" the wording of the draft Contract, so that its provisions can operate effectively whatever Parliament decides about enactment of the Bill and relevant provisions coming into effect. In practice, we have done this by introducing two new terms:

- **the 2022 Act** , defined as "the Health and Care Bill (Bill 140) once it has received royal assent"; and

- **the Commencement Date**, defined as **"**the date that a section or a paragraph of a schedule of the 2022 Act comes into force".

3.3 We have then

- retained the current references to the existing organisations and concepts listed above – and also included references to the new organisations and concepts proposed under the Bill (note that we use the name "NHS England" throughout in the text, but define it to include Monitor and NHSTDA while they continue to exist, and we have followed the same naming convention in this Guidance as well); and

- made clear that the former remain in place until they are replaced by the latter (or are simply abolished) on the relevant Commencement Date.

3.4 The changes to Contract wording giving effect to the above can be found chiefly in the Definitions section of the Contract, at the rear of the GCs.

3.5 Of necessity, this future-proofing approach involves a certain amount of imprecision or ambivalence in the wording of the Contract. We will aim to revert to more precise wording for the 2023/24 iteration of the Contract.

Planning and collaboration at system level

3.6 We have amended SC4.6 and Schedule 8 so that

- the language used will be consistent with duties on ICBs and Trusts described in the Bill and with the four strategic objectives set out for the NHS in the 2022/23 Priorities and Planning Guidance – that is, improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and supporting broader social and economic development; and

- the Contract wording refers to Joint System Plans (rather than the current term, Local System Plans), recognising the new arrangements in the Bill for "joint forward plans", covering a five-year period, to be agreed between an ICB and its partner Trusts and published.

3.7 For the last two years, as NHS system working has been developing, we have published a model System Collaboration and Financial Management Agreement (SCFMA). And there has been a Contract requirement (at SC4.7) that CCGs and partner Trusts must sign, and act in accordance with, an SCFMA, setting out how they will work together to manage NHS system finances.

3.8 With ICBs being formally established, along with new legal duties on ICBs and partner Trusts to work together to deliver system financial balance, alternative ICB governance arrangements (ICB sub-committees or joint committees with Trusts) will soon exist through which the aspirations set out in our model SCFMA can be delivered. In recognition of this (and in accordance with engagement feedback), we propose to remove from the Contract the requirement for CCGs and Trusts to sign up to an SCFMA – but we are continuing to publish a model SCFMA which can be used where local systems wish to adopt it.

Delegation

3.9 The Bill makes provision for NHS England to delegate certain functions to ICBs – and for an ICB to decide to delegate certain of its functions to an NHS Trust or an NHS Foundation Trust.

- **Delegation by NHS England.** Plans for delegation of certain commissioning responsibilities by NHS England, to ICBs, from 1 July 2022, are well-advanced – subject, of course, to the passage of the Bill and approval of the necessary detailed arrangements. For 2022/23, delegation of this kind will, mostly, affect primary care services, which will not be relevant for users of the NHS Standard Contract – but secondary care dental services in some areas may also be affected. Plans for the further roll-out of delegation to cover other NHS England commissioned secondary care services, potentially for 2023/24, will be confirmed in due course.

- **Delegation by an ICB.** Where an ICB, once established, determines that using this delegation provision would be beneficial for its population, there may be a case for recording the formal delegation agreement in a schedule within the NHS Standard Contract between the ICB and the relevant Trust. The provision in the Bill will be governed by secondary legislation and statutory guidance. The designate members of the ICB board, once appointed, will need to review and make their final decision on any such delegation proposals in accordance with this governing secondary legislation and relevant guidance once issued. At this stage, therefore, we have not included any new provisions in the Contract relating to delegation, but this is something we will look at further for the future.

Changes to national quality standards

3.10 As described in paragraph 3.19-23 below, we have moved the national quality standards from Schedules 4A and 4B in the Particulars to a new location (Annex A) at the rear of the SCs. But we have also made changes to the content of the standards themselves, reflecting new and revised requirements set out in the

2022/23 Priorities and Operational Planning Guidance and in the delivery plan for tackling the COVID-19 backlog of elective care.

- We have amended the zero tolerance standard for delays in handover from ambulance to A&E, setting this at 60 minutes, with additional requirements that (at least) 95% of handovers must take place within 30 minutes and 65% within 15 minutes.

- We have amended the zero tolerance standard for 12-hour waits in A&E, setting a requirement instead that no more than 2% of patients must wait over 12 hours. (Note that this 12-hour standard is now to be measured from the point of arrival in A&E to discharge, admission or transfer – rather than, as has previously been the case, from the decision to admit to admission.)

- We have amended the zero tolerance standard for 52-week RTT waits, setting this instead at 104 weeks. As set out in the delivery plan for tackling the COVID-19 backlog of elective care, this standard takes effect from July 2022.

- We have included, for the first time, the national two-hour urgent response time standard for community health services, with a performance threshold set at a minimum of 70%, to apply from 1 January 2023.

- The Contract has for some years contained, at SC3.15, a reference to the Access and Waiting Time Standard for Children and Young People with an Eating Disorder. We have now moved this reference so that it sits with the other national standards at the rear of the Service Conditions, with a performance threshold set at 95% for children and young people in need to begin treatment within 1 week for urgent cases and 4 weeks for non-urgent cases.

Expectations of the NHS will of course be reviewed for 2023/24 and beyond, with the aim of reverting to more demanding minimum standards – in Planning Guidance and in the Contract – at the earliest realistic opportunity. The delivery plan for tackling the COVID-19 backlog of elective care now sets out the expected performance trajectories beyond March 2023.

The Contract continues to contain a range of other long-established national standards on access and waiting times, delivery of which has been impacted by the pandemic. Examples include the 92% standard for 18-week RTT performance, the 99% standard for diagnostic test waiting times, the 95% standard for four-hour waits in A&E and the 75% Faster Diagnosis Standard for cancer. Except where the Planning Guidance has proposed a specific alternative for 2022/23, we have not amended these standards in the 2022/23 Contract. Providers should continue to do everything they can to optimise their performance against these standards.

Changes to reflect updated national policies

3.11 This section sets out changes which are aimed at promoting improvements in how care and treatment are delivered for patients, in line with the latest national policy direction.

Topic	Change	Contract Reference
Midwifery services – continuity of carer	NHS England has now published new implementation guidance relating to midwifery continuity of carer. This moves away from setting, at national level, a specific target for the proportion of women who should receive continuity of carer. Rather, the focus has now shifted to the agreement of local action plans and trajectories, based on local circumstances and resources, for providing midwifery continuity of carer as the default model of care in maternity services. We have amended the Contract requirement at SC3.13 accordingly.	Service Condition 3.13 and Definitions
Interface with primary care	Detailed requirements for secondary care providers relating to their interface with local primary care services have been included in the Contract since 2017. They cover onward referral mechanisms, management of DNAs, discharge summaries and clinic letters, provision of medication, fit notes and dealing with patient queries. Implementation of these requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices. We therefore included, in the 2021/22 Contract, a requirement for the provider and the Co-ordinating Commissioner to undertake, by 30 September 2021 (and then annually), an assessment of the effectiveness of their interface working arrangements, with a specific focus on the provider's compliance with the Contract interface requirements – and to agree and implement an action plan to address any deficiencies, reporting this to their Boards. NHS England's winter plan for supporting general practice emphasises the continuing importance of this local process to improve interface working. For 2022/23, we have therefore amended the Contract wording slightly, to refer to an ongoing annual requirement for assessment (by 30 September in each year) and action planning that builds on the progress made this year.	Service Condition 3.17
Medical Practitioners Assurance Framework	The Government's response to the Paterson Inquiry has now been published. As part of the national response to recommendation 15, we have included a new requirement for providers other than Trusts to have regard to the Medical Practitioners Assurance Framework published by the Independent Healthcare Providers Network. The Framework aims to improve consistency in effective clinical governance for medical practitioners across the independent sector.	Service Condition 3.18
Mental Health Units (Use of Force) Act 2018	Regulations have been laid before Parliament to bring into effect the Mental Health Units (Use of Force) Act 2018. Final statutory guidance on implementation of the Act has also been published. The Act requires each provider of inpatient mental health and learning disability services to publish a policy on the use of force in restraining patients, to provide staff training on the appropriate use of force and to identify a senior "responsible person" to oversee its compliance with the Act. recently published. We have	Service Condition 3.19 and Particulars

	added a new requirement on providers to comply with these obligations.	
Community pharmacy smoking cessation service	The Contract includes a requirement to screen inpatients for alcohol and tobacco use and to refer them, on discharge, to the relevant local authority alcohol advisory and smoking cessation services. A new smoking cessation service, provided by community pharmacies, is now available, and we have broadened the requirement to include referrals to this new service, which will be available to acute Trusts only in the first instance.	Service Condition 8.7
NHS Discharge Medicines Service	To ensure better communication of changes to a patient's medication following discharge from hospital and to reduce incidences of avoidable harm caused by medicines, community pharmacies are now operating the NHS Discharge Medicines Service. We have included a new requirement on providers of acute and mental health inpatient services to refer clinically appropriate patients into this Service, on discharge from inpatient care.	Service Condition 11.13
Use of the Lester Tool	The Contract already includes a requirement on providers of mental health and learning disability services to monitor the cardiovascular and metabolic health of Service Users with severe mental illness, in accordance with the Lester Tool. We have amended the Contract wording to make it clear that this also applies to Service Users who also have a learning disability, autism or both and who are receiving anti-psychotic medication.	Service Condition 8.9
Health literacy	We have added a new provision to require providers, when communicating with patients, to have regard to patients' health literacy. It is important that information which providers make available to patients, in whatever format and through whatever means, is always clear and functional. That way, the up to 61% of patients who find healthcare terminology complex and confusing can nonetheless understand and engage with what is being said to them – and, ultimately, apply it to themselves in order to make informed decisions about their health and care. Further resources on health literacy are available here.	Service Condition 12.4
National Quarterly Pulse Survey	The NHS People Plan made a commitment to introduce a new quarterly survey for NHS staff. In April 2021, the Staff Friends and Family Test was replaced by the National Quarterly Pulse Survey, and we have added a new requirement for Trusts to implement the National Quarterly Pulse Survey. (The requirement on all providers to carry out the Friends and Family Test Surveys in accordance with FFT Guidance is not changed.)	Service Condition 12.6 and Definitions
Antibiotic prescribing	The Contract has, since 2019, contained a requirement on Trusts to make 1% year-on-year reductions in their rate of total antibiotic usage per 1000 admissions – in accordance with the direction set in the UK National Action Plan (NAP) for antimicrobial resistance. We have made two changes to this requirement for 2022/23. • The first is to limit its scope to the antibiotics in the World Health Organisation's (WHO) "Watch" and "Reserve" categories – no longer, therefore, including those from the "Access" category. This accords with the clinical priority ascribed by WHO and in the NAP to achieving higher reductions in the use of the broad-spectrum antibiotics in the "Watch" and "Reserve" categories. Making this change removes any perverse incentive to reduce total antibiotic	Service Condition 21.3 and Definitions

	consumption by using one drug from the "Watch" or "Reserve" groups instead of two narrower spectrum drugs from the Access group. • The second change, consequent on the first, is to re-set the reduction targets required in the Contract. The NAP sets an ambition to reduce the prescribing of antibiotics from the "Watch" and "Reserve" groups in hospitals by 10% from a baseline of 2017. The Contract requirement is set against the 2018 baseline, and to achieve the NAP 10% target now requires a cumulative reduction of 4.5% from the 2018 baseline by March 2023 and 6.5% by March 2024. We are confident that these revised targets are stretching but achievable, and we have therefore included them in the Contract. Note that the contractual requirement here remains for "reasonable endeavours" to be used to achieve the intended reduction. There is – of course – no expectation that efforts to deliver the overall reduction should prevent individual patients from receiving necessary medication where clinically appropriate.	
Coronavirus vaccination	We have included a new requirement for providers to use all reasonable endeavours to ensure that all frontline staff are vaccinated against coronavirus. (This builds on the existing requirement relating to influenza vaccination.)	Service Condition 21.4
Assessment and treatment for acute illness	We have removed the specific requirement on providers to have regard to guidance relating to venous thromboembolism, catheter-acquired urinary tract infections, falls and pressure ulcers and provide an annual report to the Co-ordinating Commissioner on their performance in this area. This is not intended to downplay the ongoing importance of these clinical areas, and providers and commissioners should continue to monitor quality of care locally through normal clinical governance mechanisms. But the advice of the NHSE/I Patient Safety team is that continuing to encourage a focus on these four specific "harms" to patients could result in an unhelpful "skewing" of what is reported to commissioners, detracting attention from what might be other more pressing local issues.	Service Condition 22.1 and Schedule 6A
Safeguarding	We have amended the provisions relating to safeguarding to include specific reference to compliance with the Domestic Abuse Act 2021. (Note that the Government has been consulting on draft statutory guidance to support implementation of the Act.)	Service Condition 32.3
Discharge Summaries	NHS Digital has now published a new Information Standard (DAPB4042), dealing with electronic transmission of discharge summaries from hospitals to GPs following acute inpatient care (addressed in SC11). The standard is for full implementation by 31 October 2022. We have incorporated the Standard into the definition of Discharge Summary within the General Conditions of the Contract; we have also updated the definition of Delivery Method. This is the first of four message standards to be approved by NHS Digital for transfer of care, the others being Inpatient and Day Case Discharge Summary for Mental Health, Emergency Care Discharge Summary, and Outpatient Clinic Letter. These are planned to go through the DAPB approval process during 2022/23. Secondary care service providers are encouraged to	Definitions

	adopt these other Transfer of Care APIs for other use cases as early as possible, without waiting for further Information Standard publications.	
Seven Day Services	Revised seven day services clinical standards have just been published, alongside an updated seven-day service Board Assurance Framework for use by Trusts. These are referenced in Service Condition 3.11-12. We have updated the relevant Definitions in the Contract accordingly.	Definitions

Changes to relating to national care models and Primary Care Networks

3.12 We propose to continue to strengthen requirements on providers to work with commissioners, Primary Care Networks (PCNs) and others to establish new national care models for certain out-of-hospital services, as set out originally in the five-year framework for GP contract reform.

3.13 The 2021/22 Contract included, at Schedule 2Aii, detailed requirements for mental health providers to support PCNs by employing mental health practitioners (MHPs) embedded in local PCN teams. The national intention for 2022/23 is to encourage an expansion in the numbers of MHPs, the funding flow for this coming in part via the PCN Additional Roles Reimbursement Scheme in the GP contract – confirmed details of which have now been announced for 2022/23. We have therefore now published, as a stand-alone document, a revised Schedule 2Aii. This allows for numbers of MHPs to be increased where there is local agreement and includes a slightly revised role description, with scope to employ or engage non-registered staff. Note the following points.

- The arrangements in the Schedule differentiate between smaller and larger PCNs – more MHPs are envisaged for PCNs with a population over 100,000.
- Half of the funding for MHPs is to come to the mental health provider from the PCN (the Schedule refers to this as "Match Funding"); the source for the remainder of the funding is for discussion between the mental health provider and the commissioner.
- The Schedule is carefully drafted to set different expectations in respect of MHPs for adults/older adults and MHPs for children / young people. Employment of MHPs for children / young people is not mandatory, but can be done where there is local agreement between the mental health provider, the commissioner and the PCN. With MHPs for adults / older adults, the initial requirement to employ an MHPs / MHPs (from 2021/22) is mandatory on the provider, where the PCN asks for it to be implemented; the further expansion for 2022/23 is not mandatory, but can be taken forward where there is local agreement.
- Given the stage at which we are publishing the final version of the Schedule, it may need to be included in relevant local contracts post-signature, by means of a Variation.

3.14 As set out in the 2022/23 Priorities and Operation Planning Guidance, the new national Anticipatory Care operating model will be rolled out from 2023/24. During

2022/23, systems will therefore need to work with a range of local providers, including PCNs, community health services, social care, mental health providers and acute providers to design, develop a system plan for and commission delivery of Anticipatory Care, in line with the forthcoming national guidance. We will publish an example Anticipatory Care service specification; this will be available for adaptation and use locally during 2022/23, and it is anticipated that it will then become part of the Contract for 2023/24.

Changes relating to facilities and the environment

3.15 This section sets out changes in provisions of the Contract relating to green NHS issues and NHS facilities and estates.

Topic	Change	Contract Reference
National Standards of Healthcare Cleanliness	We have added a requirement to comply with the National Standards of Healthcare Cleanliness published in April 2021. These standards apply to all providers of NHS-funded services, apart from, at this stage, ambulance and patient transport services. (Further work is being done at national level to develop appropriate standards for these services.) Separate guidance sets out timescales for implementation.	Service Condition 17.1 and Definitions
NHS Premises Assurance Model (PAM)	We included, in the 2021/22 Contract, a new requirement on Trusts to complete the safety and patient experience domains of the NHS PAM. As part of the planned roll-out of the PAM, we have now expanded this requirement to cover all five PAM domains – safety, patient experience, efficiency, effectiveness and organisational governance.	Service Condition 17.9
Green NHS	We have continued to strengthen the requirements in the Contract on green issues, in line with commitments set out in Delivering a 'Net Zero' National Health Service. Changes made for 2022/23 are set out below. • Providers have already met the target of 90% of their fleet being "low-emission". Accordingly, in line with the NHS Long Term Plan commitment, we have changed the Contract to require transition to "ultra-low and zero emission" vehicles as quickly as reasonably practicable. • In support of this, we have added a new requirement on providers to develop plans to install electric vehicle charging infrastructure for fleet vehicles at their premises. • We have added a new requirement on providers to ensure that any car leasing schemes for staff (including salary sacrifice schemes) do not allow use of high-emission vehicles. • Providers have met the target of reducing the proportion of desflurane to volatile gases used in surgery to 10%. In line with Delivering a 'Net Zero' National Health Service, we have now reduced the Contract target for desflurane use to 5% or less. • We have added a requirement on Trusts to adhere to the requirements set out in *Taking Account of Social Value* (Cabinet Office Procurement Policy Note 06/20). This will mean that, in any tender evaluation a Trust undertakes, it will	Service Condition 18

	need to place a minimum 10% weighting on criteria related to social value.	
Car parking	We have updated the definition of NHS Car Parking Guidance to reflect the latest national position published at https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles/nhs-patient-visitor-and-staff-car-parking-principles.	Definitions

Changes relating to the NHS e-Referral Service and to patient choice

3.16 This section sets out proposed changes in provisions of the Contract relating to use of the NHS e-Referral Service to the operation of the legal right of patient choice of provider.

Topic	**Change**	**Contract Reference**
Listing of services on e-RS	We have become aware of instances where providers are listing their services on the wrong "menu" within the NHS e-Referral System (e-RS). Under e-RS, there are two options: • the "secondary care menu", for services to which the legal right of choice applies under the NHS Choice Framework and which must be made available to referrals from all CCGs/ICBs in England; and • the "primary care menu" for services outside the scope of the legal right of choice, which have been commissioned specifically by one or more CCGs/ICBs and which must be made available to referrals from those CCGs/ICBs only. It is essential that services are made available on the correct menu, and we have added a specific requirement on providers to ensure this, in consultation with the relevant CCGs/ICBs.	Service Condition 6.2 and Definitions
Use of e-RS for mental health and learning disability services	The Contract has, since 2019, included an obligation on providers of elective mental health and learning disability services to list their services on e-RS. We recognise that – while moving towards use of e-RS for these services remains the national direction of travel – many providers have not been able to make significant progress on this during the pandemic. We have therefore softened the contractual requirement slightly, so that the provider must use "reasonable endeavours" to list its services on e-RS.	Service Condition 6.4
Legal right of choice of provider	The Contract 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 (i.e. on a "non-contract activity" basis). 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 CCG/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 CCG/ICB. So if the provider has a contract for service X to be provided in location A, that of	Service Condition 6.13

	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. This point has been made clear for some time in our Contract Technical Guidance, and we have now made amendments to SC6.13 to make this explicit. However, it is absolutely not our intention to put obstacles in the way of the expansion of safe choices for patients. Existing legislation on patient choice and procurement places obligations on commissioners to promote choice locally. And it is clear from the delivery plan for tackling the COVID-19 backlog of elective care that 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. Where providers are able to offer new, clinically appropriate elective services (or existing services from new locations), we want to see them properly and swiftly accredited by local commissioners. Where providers meet local criteria for those services (which must be transparent, proportionate and non-discriminatory), providers should be awarded NHS Standard Contracts for those services without delay (with payment dependent on actual activity ultimately undertaken). For in-scope providers, the Increasing Capacity Framework offers a convenient means through which such contracts can be awarded. See paragraph 25.21 below for further detail.	

Online presentation of the Contract

3.17 We have made a set of changes so that 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 exist solely in their up-to-date online form, as published by NHS England from time to time; they will be incorporated into, and will apply automatically as part of, each local contract by reference only. The only element of the Contract exchanged between the parties locally will be the Particulars, which set out the locally agreed elements.

3.18 This approach will simplify the presentation of the Contract, making it easier for those using it to focus on the key elements they need to complete locally. It will contribute to the NHS green agenda, in that the GGs and SCs (which, together, comprise over two-thirds of the content of the Contract mandated by NHS England) will not need to be printed locally for each contract. And it will mean an end to the need for National Variations by which the national terms of multi-year contracts have to be updated locally, thus cutting out a time-consuming local administrative process.

3.19 The changes are given force, chiefly, by new wording on page 7 of the Particulars and by amended definitions of the GCs and SCs. But, to make the new arrangements work, we have made two further material changes.

- We have removed, from GC13, references to the National Variation process. 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 – as now – have the option to terminate its contract, on notice, on a "no fault" basis under GC17.

- We have moved the nationally mandated content previously in Schedules 4A and 4B (national quality standards) and Schedule 6F (provider data processing agreement) into a new section (Annexes A and B) at the rear of the Service Conditions. This will allow NHS England to update these national terms from time-to-time as necessary without requiring parties to contracts to update their own Particulars. The elements which require local completion (local quality requirements and the details of any specific data processing services) remain in the Particulars.

3.20 Several related points should be emphasised here.

- 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, as now, it will not be 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.

- As currently, NHS England will 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, as before, 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 will be 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 commissioner and provider to keep themselves informed of the current terms.

- The current P, 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.

3.21 The move to online presentation described above means that NHS England will no longer make available the current eContract system. (The eContract system has allowed a "tailored" version of the SCs to be produced and printed locally, including only those provisions which are relevant in the case of a specific provider

– but this is now redundant under the online approach.) This has two consequences.

- We have retained, in the SCs, the current arrangement 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 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").

- 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 of the SCs. As a result, we have been able to make some further simplifications of the Particulars, removing detail which was previously included simply to drive eContract "tailoring". This again helps to make the local process of completing contract documentation simpler and less time-consuming. See pages 9-10 of the Particulars for further detail.

4 Other issues

Preparing contract documentation for 2022/23

4.1 As described above, some significant structural changes are expected to take place in-year during 2022/23 – the establishment of ICBs and the abolition of CCGs, for example, and the delegation of commissioning responsibility for certain services from NHS England to ICBs. These potentially make it more complicated to complete local contract documentation on the right basis at the start of the year. We suggest these key points are borne in mind.

- Collaborative commissioning and contracting (with multiple commissioners signing the same single contract with a provider) is strongly recommended. See paragraphs 2.4 and 13.

- The transfer of contracts from CCGs to ICBs (see paragraph 2.3) will be much more straightforward if, as a minimum, detailed contractual requirements on each provider are fully aligned across all of the CCGs which will be replaced by a single successor ICB.

- Boundary changes associated with the establishment of ICBs need to be planned for. In a small number of situations, the population of one CCG will be split across more than one future ICB. Where this applies, the opening contracts signed by the CCG should clearly identify, in the relevant schedules, the split of activity and finance by future ICB.

- Similarly, it may be necessary for NHS England's opening contracts covering secondary care dental services to identify the activity and financial values

associated with those ICBs to which commissioning responsibility is planned to be delegated from 1 July 2022.

All of these steps will help to ensure clarity at the point of in-year transfer of responsibility from one commissioning organisation to another.

Queries and updates

4.2 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact england.contractshelp@nhs.net (note the new address) if you have questions about this Guidance or the operation of the NHS Standard Contract in general.

4.3 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

4.4 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.

4.5 Model sub-contracts suitable for use with the full-length Contract and with the shorter-form Contract are available on the NHS Standard Contract 2022/23 webpage. See also paragraph 38 below.

Section A General guidance on contracting

5 Terminology

5.1 Throughout this guidance, we continue to use the generic term "the NHS Standard Contract" or "the Contract" to refer collectively to both the full-length and shorter-form versions. Where there are material differences in approach between the two versions of the Contract, we identify these below.

5.2 Obligations under the Contract are expressed in different ways. We are sometimes asked to explain what expressions such as "use reasonable endeavours to" or "have regard to" mean, in practical terms. We have 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 – including when the NHS Standard Contract should be used, contract signature, collaborative contracting, contract duration and extension, dispute resolution, and non-contract activity.

7 When should the NHS Standard Contract be used?

7.1 The NHS Standard Contract exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of provider and allowing economies in the drafting and production of contracts, for example in respect of legal advice.

7.2 Currently, by its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, NHS England mandates that the NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services). (The Health and Care Bill envisages similar powers for the future in respect of ICBs.) The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.

7.3 The only exceptions are:

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

7.4 CCGs/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 CCG/ICB is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements.

7.5 The NHS Standard Contract is neither mandated nor intended for use by provider organisations when contracting with other provider organisations for the provision of clinical services. In most circumstances such arrangements will be correctly

categorised as a sub-contracting of services commissioned under an NHS Standard Contract – on which see paragraph 38 below.

8 Promoting collaboration and contracting for integrated services

8.1 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. The Health and Care Bill is intended to bring about a further strengthening of these partnership arrangements, and separate guidance has been provided to the NHS about the development and governance of the new arrangements. Contractual models for driving better integration of services continue to have relevance, though, and this section describes some of the available approaches.

Integrated Care Provider Contract

8.2 We have previously designed a variant of the NHS Standard Contract for use for commissioning an integrated package of services for a population, potentially including primary medical care, through a lead provider – the Integrated Care Provider (ICP) Contract. We will reassess any potential role for the ICP Contract in the future as ICBs take firmer shape.

Contracting for integrated primary and secondary care

8.3 Outside of the ICP approach, if a commissioner wishes to place a contract for integrated secondary and primary medical care services, it remains able to 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. An updated template form of those further provisions, for inclusion in Schedule 2L where appropriate, is available on the NHS Standard Contract 2022/23 webpage along with guidance about their use.

8.4 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

8.5 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.

8.6 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.

Integrated Support and Assurance Process for novel and complex contracts

8.7 Innovative contracting approaches can offer benefits, but they may also involve risks. In this context, NHS England have published the Integrated Support and Assurance Process: guidance on assuring novel and complex contracts (ISAP). ISAP has two purposes: to support the work of local commissioners and providers in creating successful and safe contracts, and to provide a means of assurance that this has happened.

8.8 Examples of complex contracting arrangements, likely to fall within the scope of ISAP, will include:

- commissioning systemically significant new care models that result in significant changes in local health systems;
- contracts aiming to integrate services along a care pathway, such as for older people or cancer patients; and
- contracts which include complex delivery and reimbursement mechanisms for specialised services or with population-based budgets or significant levels of payment conditional on outcomes.

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

8.10 ISAP is likely to evolve as ICBs develop and as the proposed new Provider Selection Regime takes effect. Further guidance will be published as necessary.

9 When to use the shorter-form Contract

9.1 The shorter-form Contract must not be used for contracts under which acute, cancer, A&E, 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 In line the arrangements for CQUIN under the Aligned Payment and Incentive (API) Rules introduced under the National Tariff during 2021/22, we have removed all references to CQUIN from the shorter-form Contract. The shorter-form version must not be used where the API Rules and CQUIN apply. See also the more detailed guidance in paragraph 46.27-28 below on how the financial impact of this is to be managed for providers operating under the shorter-form Contract.

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.

9.8 Note that, under the current procurement regime, when services are being tendered, the same form of contract must be offered to all potential providers of

those services. The form of contract offered (whether shorter-form or full-length) should be made clear in the Prior Information Notice, advertisements and other communications with potential providers. The new Provider Selection Regime may offer more flexibility: guidance on that will be published in due course.

10 What elements of the Contract can be agreed locally

10.1 The elements of the Contract for local agreement fall within the Particulars. The Service Conditions may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The General Conditions must not be varied at all.

10.2 Commissioners must not:

- put in place locally designed contracts or service level agreements for healthcare services, instead of the NHS Standard Contract; or
- vary any provision of the NHS Standard Contract except as permitted by GC13 (Variations); or
- seek to override any aspect of the NHS Standard Contract.

10.3 Where commissioners and providers wish to record agreements they have reached on additional matters, they may use Schedule 2G (Other Local Agreements, Policies and Procedures) or (in the full-length Contract) Schedule 5A (Documents Relied On) for this purpose. Commissioners are reminded that any such local agreements must not conflict with the provisions of the Contract. In the event of any such conflict or inconsistency, the provisions of the Contract will apply, as set out in GC1.

11 Use of grant agreements

11.1 Where voluntary sector organisations provide healthcare services, or other services in support of the healthcare needs of the local community, commissioners may choose to provide funding support for those services through grant agreements, rather than using the NHS Standard Contract.

11.2 Use of the Standard Contract is, however, necessary where it is clear that the commissioner is commissioning (as distinct from providing funding support for) a specific clinical service (as distinct from non-clinical or clinical support services) from a voluntary sector organisation. (Note also that, whatever the nature of the services being provided, if those services are being competitively tendered and potential providers include both voluntary sector and other types of provider, the same form of contract must be offered to all potential providers of the relevant service – which precludes the use of a grant agreement.)

11.3 However, where the commissioner is providing funding support towards the costs a voluntary sector provider faces in running a service (and especially where some of the providers' costs are being met by donations and/or payments by service users), it will generally be more appropriate for commissioners to use a grant

agreement rather than the Standard Contract, and we would strongly urge them to do so. This will apply to some hospice services, for example.

11.4 NHS England has published a non-mandatory model grant agreement for use by CCGs/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 3A (Local Prices). Where individually priced packages of care for new patients are likely to be agreed in-year based on differing inputs from different staff types, Schedule 3A can also record the agreed unit prices for such inputs. It should be possible to avoid having to vary the contract formally in-year to record each new or revised individual care package. The call-off / framework arrangements described in section 27 below will often work well for CHC, allowing the detailed requirements for an individual service user to be set out in a specific Individual Placement Agreement, which sits within an over-arching contract with the provider.

12.4 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 Since September 2020, new "discharge to assess" arrangements have been in place, meaning that most patients will no longer undergo CHC assessment in hospital. Many will instead be discharged to short-term CCG/ICB-funded residential care placements, where their requirements for longer-term care can be properly assessed. The same principles apply to the commissioning of the capacity for these short-term placements, which should be undertaken 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 will remain an important tool, as it has been 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. This is particularly important for the opening contracts which CCGs agree with providers for 2022/23, which will then transfer to ICBs. The transfer will be much more straightforward if, as a minimum, contractual requirements on the provider are fully aligned across all of the CCGs which will be replaced by a single successor ICB.

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 Model CCAs are available on the NHS Standard Contract web page.

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

14 Which commissioners and providers can be party to the Contract

14.1 The Standard Contract must be used by CCGs/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 CCG/ICB that he or she has the wherewithal to deliver the contract in accordance with its terms.

15 Signature of contracts and variations

15.1 A contract must be signed by an appropriately authorised signatory of each party to it. Where a group of commissioners wishes to enter 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.

15.2 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.

15.3 We recognise that the collection of signatures from commissioners is a time-consuming process. Variations may therefore be signed by the provider and the co-ordinating commissioner (on behalf of all commissioners) only, rather than by all commissioners (see GC13.3). Commissioners must therefore ensure that their collaborative agreements set out very clear arrangements through which Variations are agreed amongst commissioners, prior to signature by the co-ordinating commissioner. The co-ordinating commissioner must maintain a record of evidence that each variation has been properly approved by all commissioners (whether or not they are directly affected by the variation – because all are parties to the contract being varied) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.

15.4 We recognise that use of electronic signatures (via appropriate internal governance procedures and IT software) for signing of legal documents is becoming common in some areas of commerce, 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.

15.5 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.

16 Legally binding agreements

16.1 The contract creates legally binding agreements between NHS commissioners and Foundation Trust, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract documentation, and their contracts should be treated by NHS commissioners with the same degree of rigour and seriousness as if they were legally binding. Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding between those parties.

17 Contract duration

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

17.2 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.

17.3 Equally, there will, of course, be situations where contracts with a shorter term may be appropriate, for example where the commissioning requirement is for a short-term or pilot service or where the service or supplier landscape is changing rapidly.

17.4 There is no nationally mandated limit to contract duration, nor is there a central approval process for contract terms beyond a certain duration. It is for commissioners to determine locally, having regard to the guidelines below, the duration of the contract they wish to offer.

- Commissioners will need to consider carefully what benefits they can expect from offering providers the increased certainty of a longer-term contract, setting this against the need to ensure that they are able to use a competitive procurement approach when this will be in patients' best interests, in line with regulations and guidance. Commissioners should consider patient choice, competition, the likelihood of technological and other developments affecting service delivery models, all relevant commercial and market considerations, in determining the appropriate length of contract. Contract length should be considered in conjunction with consideration of including any right to extend the contract (see paragraph 18) and/or the consequences of early termination (see paragraph 47).

- Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.

- Commissioners must ensure that the duration of any contract (and any proposed right to extend that period) is in compliance with their own standing financial instructions (SFIs) and other governance requirements, and that any approvals are obtained in line with those requirements. NHS England commissioners should note that NHS England's own SFIs set out specific arrangements for the approval, prior to advertisement, of procurement processes; commissioning teams should ensure that they review the SFIs in advance of advertisement to ensure that all required approvals have been obtained.

17.5 Alongside flexibility of contract duration, the Contract:

- includes an explicit acknowledgement of the parties' rights to terminate the Contract or any Service by mutual agreement (GC17.1); and

- continues to include provisions for early termination of the Contract or a Service on a no-fault basis, with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).

17.6 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.

18 Extension of contracts

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

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

18.3 It is essential that this provision is not misused. The guidance below is designed to reduce the risk of challenges for breach of 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, one year or two years, but not for one year then for another year).

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

19 Updating non-expiring contracts

For 2022/23

19.1 Where contracts are in place which do not expire on 31 March 2022, the parties will need to update their terms by implementing a National Variation. This will ensure that their local contract reflects up-to-date national policy requirements and the current legislative framework.

19.2 To do this, the co-ordinating commissioner and provider must complete and sign the National Variation Agreement template following our guidance (both the template and guidance will be made available in due course on the NHS Standard Contract webpage.

19.3 Where the provider refuses to accept a National Variation, commissioners will be able to issue a notice to terminate the existing contract on three months' notice, as set out in GC13.13 (GC13.4 of the shorter form) of the 2021/22 version of the Contract.

Beyond 2022/23

19.4 Under the new online approach described in paragraphs 3.19-23 above, National Variations published by NHS England will no longer be required after April 2022; rather, any updated version of the General Conditions and Service Conditions of the Contract published by NHS England after due consultation will take automatic effect.

20 Contract expiry, new contracts and notice requirements

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

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

- Equally, there is no contractual requirement for commissioners to publish generic 'commissioning intentions' by a given date. Issuing of generic commissioning intentions documents, often aimed at a commissioner's providers collectively, rather than setting out specific information for individual providers, is at the discretion of the relevant commissioner.

- However, early communication of both commissioner and provider intentions is always good practice. In terms of a possible new contract for a new financial year, it is in both parties' interests to set out their intentions clearly in time for necessary negotiations, or other processes, to be completed before any new contract is intended to take effect.

- In advance of the expiry of a contract, the commissioner should as a matter of good practice, for instance, notify the provider that it no longer wishes to commission any services (or a specific service) from that provider in the following year, perhaps because it intends to undertake a competitive procurement process. In such a case, the requirements for the procurement process to be transparent and for the incumbent provider to share information about the services and the potential impact of handover to a new provider (for example, workforce information in expectation of TUPE applying), will mean that early communication of commissioner intentions is always required.

- Similarly, a provider should as a matter of good practice notify the commissioner that it no longer wishes to provide a particular service in the following year. If the service has been designated as a Commissioner Requested Service (CRS) (see paragraph 37 below), then restrictions on the provider's ability to withdraw provision of the service will apply, in line with CRS guidance.

- There will be other instances where either party is seeking changes, in a new contract for the following year, to services commissioned or to detailed contractual provisions (local quality and reporting requirements, say). As with in-year variations to agreed contracts, there is no specific period of notice which must be given for such changes; rather, the complexity of the issues involved and the time realistically needed to implement the specific changes proposed should drive the timescale for discussions. Both parties should remember that agreeing a contract is a process of negotiation; it makes sense for all major changes which either party wishes to propose to be 'on the table' before detailed negotiations get under way, but it will often be possible to accommodate smaller changes after that point.

21 Heads of Agreement

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

21.2 Heads of Agreement are different to contracts. They are typically pre-contract agreements and are not intended to create a binding arrangement between the parties. In complex procurement and contract negotiation scenarios, Heads of Agreement (sometimes also referred to as Heads of Terms) may be useful as a way of documenting progress towards intended signature of a binding contract – but in most NHS commissioning situations, both parties will be better advised to focus on agreeing and signing the actual contract itself.

22 Changes in counting and coding practice

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

23 Resolution of disputes

23.1 Arrangements for resolution of disputes which arise once a contract has been signed are dealt with under General Condition 14.

23.2 In terms of the agreement of new contracts for 2022/23, Guidance on 2022-23 revenue finance and contracts says this:

"System working is now well established across the NHS, and commissioners and providers are urged to build on the collaborative behaviours that have developed during the pandemic and approach 2022/23 in the same spirit of partnership. NHS England and NHS Improvement have set out guidelines for agreeing the fixed value of API arrangements to support NHS organisations to confirm arrangements. In this context, NHS England and NHS Improvement are not proposing to put in place a formal process for arbitration between commissioners and Trusts where they cannot agree a contract by 31 March 2022. Rather, there will be a reliance on local NHS leaders to work together to ensure issues relating to contract agreement are resolved locally and in a timely manner. Regional teams will track local progress and will mediate 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 Non-contract activity

25.1 Non-contract activity (NCA) is the term used to refer to NHS-funded services delivered to a patient by a provider which does not, at the point at which those services are delivered, have a written contract in place with that patient's responsible commissioner, but which does have a written contract for the delivery of that service in place with at least one other NHS commissioner.

25.2 From 1 April 2022,

- as set out in the finance and contracting annex to the 2022-23 Priorities and Operational Planning Guidance (Guidance on 2022-23 revenue finance and contracts), there will be a new simplified process for low-volume flows of activity (LVA) between NHS Trusts / NHS Foundation and (generally) more distant CCGs/ICBs; and

- flows between non-NHS providers and CCGs/ICBs will continue to be governed by the existing NCA arrangements.

This is explained further below. A recorded webinar (available here on FutureNHS) provides further detail.

Note that the LVA arrangements described below

- do not apply to services commissioned by NHS England – NHS England is one legal entity and should hold one comprehensive contract with a provider, covering patients who attend from wherever in the country, so there is no need for a system such as LVA, which is there to deal with flows from multiple different commissioner entities;

- do not apply to activity flows from and to devolved administrations - commissioners and Trusts will need to revert to normal pre-pandemic arrangements for invoicing and payment.

Arrangements for NHS Trusts and NHS Foundation Trusts

25.3 This revised process – to streamline financial arrangements for managing LVA flows from commissioners to Trusts – has been developed following feedback from the consultation we carried out in 2020 and further engagement in September

2021. Both demonstrated strong support for a new, less burdensome approach. This revised process for 2022/23 now embeds some of the transactional efficiencies achieved through the temporary COVID financial frameworks, where amounts between commissioners and Trusts below £500,000 were not required to be transacted, which was universally welcomed throughout the NHS.

25.4 Key to the new approach is the LVA Payments Schedule of ICB-to-Trust relationships (other than ambulance Trusts), made available by NHS England to CCG/ICBs and Trusts on the PFMS portal, with individual values pre-populated in in CCG and Trust planning templates. The LVA Payments Schedule identifies those relationships where, on the basis of historic activity, the annual value of activity between the ICB and the Trust for 2022/23 is expected to have a value below a ceiling of £500,000.

25.5 For those relationships below the £500,000 threshold, the LVA Payments Schedule identifies a specific value to be paid in 2022/23 (or potentially a value of zero where there has been no flow of patients in the past). Each ICB should pay the amounts specified in the LVA Payments Schedule to the relevant Trusts by 30 September 2022. (Trusts should not need to send a separate invoice.) This will be a comprehensive payment, covering all services to be provided. No further payments or amounts should be transacted during 2022/23 (regardless of the actual volume and value of activity undertaken), and the annual payment values will be refreshed in advance of the start of each financial year as part of the annual planning process. This single annual payment will replace the previous costly and labour-intensive process of invoicing and validation between Trusts and distant commissioners. (One specific exception relates to patients placed with out-of-area Trusts for non-emergency in-patient mental health care. For such patients, Trusts should continue to invoice the responsible ICB; this is important to support the 'care closer to home' policy.)

25.6 Where the LVA Payments Schedule does not identify a specific value for a commissioner-to-Trust relationship in 2022/23, this means that the relevant commissioner and the Trust must negotiate, agree and sign a written contract for 2022/23; to minimise administrative workload, use of the collaborative contracting approach described in paragraph 13 above is very strongly recommended.

Arrangements for non-NHS providers

25.7 The arrangements previously in place for NCA for non-NHS provider organisations will continue in place for 20022/23, as described in the remainder of this section 25.

What contractual terms apply under an NCA approach?

25.8 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 25.10b) below).

25.9 Note in particular that:

a) services will be delivered in accordance with the service specifications and other terms and conditions of the provider's contract with its host commissioner;

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

c) arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance and the terms and conditions set out in the NHS Standard Contract; this means in practice that non-NHS providers must invoice for NCA monthly in accordance with either SC36.35A or SC36.36A (full-length Contract) or SC36.27 (shorter-form Contract);

d) commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements – but must, if they intend to do so, contest payment within the timescales set out in SC36.45 (full-length) and SC36.34 (shorter-form); and

e) commissioners and providers should work together in good faith to minimise disagreements relating to prices and payment for NCA, but any formal disputes must be resolved in accordance with the dispute resolution procedure set out in GC14 of the Contract.

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?

25.10 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.

25.11 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.

25.12 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

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

25.14 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.)

25.15 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.

25.16 These provisions continue to apply to Trusts operating under the LVA arrangements described in paragraphs 25.3-7 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).

25.17 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 25.21 below for further detail on the application of the legal right of choice.)

Commissioner prior approval for NCA activity

25.18 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 25.3-7 above, there is no requirement to seek prior authorisation.

25.19 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.

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

- a CCG/ICB cannot require a provider operating on an NCA basis to implement that CCG/ICB's Prior Approval Schemes; and

- a Prior Approval Scheme must not be used to restrict a patient's legal right of choice of provider.

Legal right of choice of provider

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

- Commissioners (CCGs/ICBs and NHSE) 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 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 (i.e. on a "non-contract activity" basis).

- 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 CCG/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 CCG/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. This point has been made clear for some time in this Guidance, and we have now made amendments to SC6.13 to make this explicit.

- However, it is absolutely not our intention to put obstacles in the way of the expansion of safe choices for patients. Existing legislation on patient choice and procurement places obligations on commissioners to promote choice locally. And it is clear from the delivery plan for tackling the COVID-19 backlog of elective care that 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.

- Where providers are able to offer new, clinically appropriate elective services (or existing services from new locations), we want to see them properly and swiftly accredited by local commissioners. Where providers meet local criteria for those services (which must be transparent, proportionate and non-discriminatory), providers should be awarded NHS Standard Contracts for those services without delay (with payment dependent on actual activity ultimately undertaken). For in-scope providers, the Increasing Capacity Framework offers a convenient means through which such contracts can be awarded.

- We will of course keep the wording of the Contract in relation to patient choice under review, as relevant regulations and guidance are updated as part of work on the Health and Care Bill and to implement the delivery plan for tackling the COVID-19 backlog of elective care.

26 Letting of contracts following advertisement

26.1 For the present, all commissioners should ensure that they are fully aware of, and comply with, the requirements and implications of the Public Contracts Regulations 2015, in respect of the advertisement, procurement, award, variation and assignment or novation of contracts for healthcare services, and which apply alongside the Procurement, Patient Choice and Competition Regulations 2013. It is anticipated that the new Provider Selection Regime will take effect in due course, subject to the passage of the Health and Care Bill – but the existing regulations remain in force at present and will continue to be so unless and until amended or repealed.

26.2 The commissioner must let a contract to the chosen provider exactly on the basis notified to potential providers in the Prior Information Notice and/or otherwise advertised. This means that there must be a separate, specific contract put in place for the procured service, rather than – if the tender has been won by a provider which already has a contract with the commissioner – the new service being 'added in' to that existing contract. To do otherwise raises a risk of challenge from other potential providers on the grounds of a breach of procurement rules and should be avoided.

27 Use of the Contract for call-off arrangements

27.1 We know that many commissioners have successfully used the Contract in the context of a framework for, for example, care home placements. 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 3A. The Commissioner then raises a purchase order (PO) or individual placement agreement (IPA) for each placement, and the PO or IPA references the Contract which is in place between the parties. (To be clear, a PO or IPA may only be used when there is an NHS Standard Contract in place with the provider; they must not be used in isolation.) Either the full-length or the shorter-form version would be fit for purpose in this context – but, as noted above, the same form of contract must be used with each provider appointed under a framework procurement. 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 CCGs/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 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 CCG/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 supply of goods and the provision of 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 locally-initiated 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 Bill 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 3.7-8 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 Other useful contacts are set out below.

- Queries relating to CQUIN can be sent to e.cquin@nhs.net
- Queries relating to *Who Pays?* can be sent to england.responsiblecommissioner@nhs.net
- Queries about the National Tariff Payment System can be sent to pricing@england.nhs.uk

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. A separate brief User Guide to the shorter-form Contract is also available.

32 Structure of the NHS Standard Contract

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

32.1 The Contract is divided into three parts.

- **The Particulars.** These contain all the sections which require local input, including details of the parties to the contract, the service specifications and schedules relating to payment, quality and information.

- **The 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.

32.2 Under the arrangements described in paragraphs 3.19-23 above, the Service Conditions and General Conditions will in future be published online and will be incorporated into each local contract by reference.

33 The e-Contract system

33.1 Also as part of the arrangements set out in paragraphs 3.19-23 above, the eContract system will no longer be required, and it will cease to be available at 31 March 2022.

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 Note that the Community Services category is aimed at out-of-hospital services. These could be provided by NHS Trusts, independent and voluntary providers, GPs or optometrists. If a provider of community services also runs community hospitals with inpatient beds, and acute contractual provisions are relevant, then the commissioner may also wish to tick the Acute Services category. Where primary medical services (for example, GP out-of-hours services) are being commissioned under an NHS Standard Contract as part of a package of services, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 8.2 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).

34.5 As described in paragraph 3.23 above, 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 of the Service Conditions.

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 locally-initiated 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, 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. For 2022/23, we have streamlined this template. In many cases, specifications in contracts should be less restrictive and input-driven in future than is often the case currently, allowing the provider more leeway 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). 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 General Condition 1.2, that the provisions in the General and Service Conditions will take precedence over the content of the Particulars, including any detail within a service specification.) However, commissioners should ensure that, within their service specifications, they use correct contract terminology listed in the Definitions in the General Conditions (for example, 'Service User' rather than 'patient').

36.7 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 services are being commissioned by NHS England, there will often be one national service specification for the particular service, which has been designed with clinical input and signed off at national level. For specialised services, for instance, the Contract mandates that national specifications must be used.

36.9 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 CCGs/ICBs when commissioning regional ambulance services.

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

(Note that, under the Health and Care Bill, changes are proposed to the scope of the NHS Provider Licence, meaning that – subject to the passage of the Bill – the concept of Essential Services will no longer be needed, as NHS Trusts will come within scope of the Commissioner Requested Services regime within the Licence provisions.)

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.

38 Assignment, novation and sub-contracting

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

38.1 GC12 governs assignment, novation and sub-contracting.

38.2 There may be circumstances where the provider wants another party to take over as provider under the contract – for example, if the provider is a company and is selling its business and assets to another company. GC12 states that the provider cannot assign or novate any of its rights or obligations under the Contract without the prior written approval of the co-ordinating commissioner. (This situation may be contrasted with the sale of shares in a provider company, to which the Change in Control provisions at GC24 apply.) An assignment and a novation are slightly different things in legal terms. An assignment of a contract by a provider will not release that provider from its obligations under the contract. A novation, on the

other hand, will effectively cancel the original contract and replace it with a new one between the commissioner(s) and the new provider. Either may have material implications under the Public Contract Regulations. Either will need to be appropriately legally documented. If approached by a provider for consent to an assignment or novation, commissioners should, before giving consent or even considering doing so:

- ask the provider to give them as much information as possible about the proposed transaction, including the reason for it, the parties involved, and the experience and capability of the proposed new provider;

- explain to the provider that the commissioners will need to take legal advice on the request, any procurement implications, and any documentation related to the assignment or novation;

- require the provider to confirm that it will cover the commissioners' costs (including legal costs) in relation to the application for consent and all matters connected with it; and

- take legal advice, as above, and proceed in accordance with that advice.

38.3 We are aware that there can be confusion about the extent to which commissioners should be involved in decisions around sub-contracting, and guidance on this is therefore set out below.

38.4 The provider is wholly responsible to the commissioners for the delivery of the services and for the performance of all of the obligations on its part under the contract. The default assumption is that the provider will actually provide the services, and everything required in order to deliver those services in accordance with the contract, itself. However, in practice, most providers will wish to or need to sub-contract elements of the services, or contributions towards their delivery, to others.

38.5 What do we mean by a sub-contract? For the purposes of the Contract, a sub-contract is defined very broadly: it is any contract entered into by the provider or by any sub-contractor for the purpose of the performance of any of the provider's obligations under the contract. So that would include contracts entered into by the provider or by its sub-contractors with providers of clinical services (often known as "provider-to-provider" contracts), clinical support services, goods and equipment on which the provider or the sub-contract relies in order to be able to deliver the services in accordance with the contract entered into with the commissioners.

38.6 It is important for both commissioners and providers to recognise that sub-contracting in no way relieves the provider from responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract: failure on the part of a sub-contractor does not excuse the provider from its obligations to the commissioners.

38.7 Nevertheless, commissioners will have an interest in sub-contracting arrangements. Depending on the scope and nature of the service or contribution being sub-contracted, they will need a greater or lesser degree of assurance as to

the identity, level of competence and experience of the sub-contractor and the terms on which it is being appointed. Overall, the level of scrutiny which any sub-contract requires from the commissioner should be in proportion to its materiality, in terms of its potential impact on patient care. Commissioners will need to strike a careful balance, aiming for an appropriate and manageable level of oversight and not for micro-management of operational detail.

38.8 GC12.1 states that the provider is not to sub-contract any of its obligations under the contract without the written approval of the co-ordinating commissioner. So the co-ordinating commissioner is able to exercise control over what, how and to whom the provider sub-contracts the performance of those obligations. The extent to which it does or should exercise that control in practice will, as suggested above, depend on the scope and nature of what is to be sub-contracted. It is important that commissioners and providers reach an understanding, in the context of their contract, as to when and how this control will be exercised. It may, for example, be readily agreed between the parties that the provider will be free to contract with suppliers of consumables and providers of support services such as catering and cleaning without seeking consent to each individual sub-contract: in effect a blanket consent is granted at the outset. On the other hand, who supplies particular consumables may, in the context of a particular commissioning contract, be very important to the commissioners, and they may therefore wish to exercise the right of approval over sub-contracts for those consumables.

38.9 GC12.2 allows the co-ordinating commissioner to designate a sub-contract as a Material Sub-Contract. "Material" in this context means that it relates to all or a significant and necessary element, or contribution towards, the delivery of a service. Materiality is not about the value of the sub-contract, or necessarily about whether or not the subject matter of the sub-contract is itself a clinical service; the key is the importance of the sub-contract and the sub-contractor to the delivery of the provider's services. If a sub-contract is designated by the commissioner as a Material Sub-Contract, specific controls will apply, governing its termination, variation or replacement (see GC12.5).

38.10 It is important that the co-ordinating commissioner makes it clear to the provider, before awarding a contract:

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

38.13 Where NHS providers are placing sub-contracts for non-clinical goods and services, they may appropriately use the standard NHS terms and conditions for procuring goods and services, published by the Department of Health and Social Care. Where the sub-contract is of a clinical service, the goods and services contract will not be suitable.

38.14 NHS England produces model sub-contracts for use by providers for clinical service sub-contracting, for use with the full-length NHS Standard Contract and with the shorter form Contract. These model sub-contracts, 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 2022/23 Contract and republished on the NHS Standard Contract 2022/23 webpage. Note that we now publish a version of the model sub-contract under which multiple head providers can place a single sub-contract with a chosen sub-contractor.

38.15 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.

38.16 Where a provider does not use the national model sub-contract, it should ensure that the sub-contract it does put in place reflects the relevant elements and requirements of the NHS Standard Contract.

38.17 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. Instead, NHS England has published a template agreement which can be used – see Innovative employment models for PCNs.

Management of sub-contracts

38.18 Management of the sub-contractor is the responsibility of the provider. The provider is responsible to the commissioner for all of the services, including any provided by sub-contractors. However, the co-ordinating commissioner does have powers to require the replacement of sub-contractors in specific situations, as set out in GC12.13 (full-length Contract).

39 Quality of care

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

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

Using the Contract to manage quality – an overview

39.2 Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and hold it to account for the quality of care it (and any sub-contractors) delivers. The key elements of the Contract dealing with quality are summarised below.

- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).

- The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every twelve months; they must undertake quality impact assessments before making material changes to staffing levels; and they must implement a standard operating procedure for responding to day-to-day shortfalls in staff numbers.

- The Contract requires providers to adhere to national guidance on specific service areas, such as hospital food standards (SC19), infection control (SC21), safeguarding (SC32), the care of dying people (SC34) and the duty of candour (SC35).

- The Contract sets specific national quality standards which the provider must achieve (Annex A of the Service Conditions), with scope for additional local quality requirements (Schedule 4).

- 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 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 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. Local Quality Surveillance Groups offer an important forum through which commissioners can share information and intelligence about service quality with their local commissioning and regulatory partners. Updated guidance on how to run an effective Quality Surveillance Group has been produced by the National Quality Board.

39.4 Detailed guidance on reporting requirements 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 now set out in Annex A of the Service Conditions, combining what have previously been labelled and listed separately as National Quality Requirements and Operational Standards. 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 3.10 above, which deals with the issue of post-pandemic performance.

39.6 Links to the detailed definitions for the National Quality Requirements are provided within Annex A of the Service Conditions.

Local Quality Requirements

39.7 Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. As a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value. Provisions are set out in SC28 to address this (see paragraph 43.6 below).

39.8 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.

39.9 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. Note that the Getting It Right First Time programme has now published Good Practice Commissioning Guidance for orthopaedics and spinal surgery; this will be a useful source of potential local quality requirements.

Patient Safety

39.10 In line with NHSE's revised NHS Patient Safety Strategy, the Serious Incident Framework and Never Events Policy and Framework remain in place, but are intended to be replaced in due course by a new Patient Safety Incident Response Framework. SC33 requires providers to comply with the existing frameworks and any successors.

39.11 In finalising and agreeing Schedule 6A (Reporting Requirements) and Schedule 6C (Incidents Requiring Reporting Procedure), commissioners should ensure that the following requirements are clear:

- The provider must report any Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) in line with the timeframes set out in the Serious Incident Framework and ensure such incidents are also reported to the National Reporting and Learning System.

- The provider must investigate any SI using appropriate Root Cause Analysis methodology as set out in the NHS Serious Incident Framework and relevant guidance or, where reasonably required by the commissioner in accordance with the Serious Incident Framework, commission a fully independent investigation.

- The outcomes of any investigation, including the investigation report and relevant action plan should be reported to the commissioner within the timescales set out in the Serious Incident Framework.

- The provider and commissioner must ensure that the processes and principles set out in the Serious Incident Framework are incorporated into their organisational policies and standard operating procedures.

- The provider must operate an internal system to record, collate and implement learning from all patient safety incidents and will agree to share such information with the commissioner as the commissioner reasonably requires. (This is a requirement under the more general provisions in SC3.4.)

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

- The Contract requires each provider to designate one or more Patient Safety Specialists (see SC33.7). It should also be noted that two previous Patient Safety Alerts (psa-med-device-inci.pdf (england.nhs.uk) and psa-med-error.pdf (england.nhs.uk)) have required large providers to appoint both a Medication Safety Officer (MSO) and a Medical Device Safety Officer (MDSO); DHSC has published detailed guidance on the latter. It is important that providers ensure that both MSOs and MDSOs are in place, and we will consider consulting on making this a contractual requirement in future.

Contract provisions relating to the primary / secondary care interface

39.12 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.

39.13 The Contract "interface" provisions now cover

- referral, including the management of DNAs and onward (consultant-to-consultant) referrals (SC6, SC8 and SC29);

- communication with primary care on discharge from hospital and following clinic attendance (SC11);

- provision of medication following hospital admission or attendance, and use of shared care protocols (SC11);

- provision of fit notes to patients (SC11); and

- managing patient care and investigations and communicating with patients and dealing with their enquiries (SC12).

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

39.14 Implementation of these requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices. The Contract now 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.

39.15 Useful resources for providers and commissioners, including a summary of the Contract requirements for clinicians and managers and a practical implementation toolkit, are available at https://www.england.nhs.uk/gp/gpfv/workload/interface/resources/. It remains an extremely important priority for NHSE that the Contract requirements in this area are fully implemented at local level.

Referral, management of DNAs and onward referral

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

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

NHSE on the Future NHS website; providers should review their existing policies and ensure that they are consistent with this model version.

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

- the onward referral is directly related to the condition for which the original GP referral was made or which caused the emergency presentation (unless there is a specific local CCG/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

39.19 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/.

39.20 NHS Digital has provided guidance to support providers in implementing electronic discharge summaries and clinic letters, and further details on the structured approach to sharing clinical information are set out in the NHS Digital's 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. NHS Digital has now published a new Information Standard 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 by NHS Digital for transfer of care, the others being Inpatient and Day Case Discharge Summary for Mental Health, Emergency Care Discharge Summary, and Outpatient Clinic Letter. These are planned to go through the DAPB approval process during 2022/23.

39.21 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.

39.22 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).

39.23 Note that NHS Digital has published a new Information Standard (DAPB4017) to enable the sharing of pathology results across the NHS, including across care settings and organisational boundaries.

39.24 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

39.25 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.

39.26 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

39.27 Service Condition 26 of the full-length Contract contains provisions relating to research studies.

- The Contract continues to place an overarching obligation on every provider of NHS-funded services to support research activity by assisting with the recruitment of suitable subjects (whether patients or staff) into properly-approved research studies (including where these are being conducted by a different organisation) (SC26.3).

- The Contract does not require providers of healthcare services to participate in research studies and fund these from within the income they receive from commissioners. Rather, research studies will be set up with separate funding streams and with specific agreements in place between the research sponsor and the organisation carrying out / participating in the study.

- However, the Contract does require that, for commercial contract research studies, any provider operating under the Contract wishing to conduct or participate in the study must (under SC26.4) do so in accordance with the National Directive on Commercial Contract Research Studies published jointly by NIHR, HRA and NHS England (updated 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; note that new guidance in this area has now been published.

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.

For 2022/23, we have also removed the separate arrangements for Local Incentive Schemes (previously in SC38 and Schedule 4D), which are now redundant. The national financial incentive scheme, CQUIN, applies to those contractual relationships which fall within scope of the Aligned Payment and Incentive rules in the National Tariff Payment System and is documented in Schedule 3E. Any other agreed local arrangements for financial incentives should be recorded in Schedule 3A (Local Prices).

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 4C is in place with a provider and does not expire at 31 March 2022, the commissioner will be able, at its discretion, to retain those sanctions within the local contract for 2022/23.

40.3 For new contracts, commissioners wishing to build in financial incentives or a "pay-for-performance" regime (over and above CQUIN) can do so by setting out their approach in Schedule 3A (Local Prices).

41 The Service Development and Improvement Plan (SDIP)

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

41.1 The Service Development and Improvement Plan (SDIP, Schedule 6D) allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.

41.2 SDIPs differ from Remedial Action Plans (RAPs) under GC9 (Contract Management). RAPs are put in place to rectify contractual breaches or performance failures, whereas an SDIP is generally about developing an aspect of the services beyond the currently agreed standard. (Note however that, where specific actions and consequences are set out in a RAP under a contract which is soon to expire, commissioners may opt to roll those requirements into an SDIP under the provider's new contract, to ensure that the matters agreed are not lost in the switch from one contract to the next). Once included in the Contract, commitments set out in SDIPs are contractually binding.

41.3 Unless specifically mandated in the guidance below, SDIPs are for local agreement between the parties. SDIPs may for instance include:

- productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or
- any agreed service redesign programmes; or
- any priority areas for quality improvement (where this is not covered by a quality incentive scheme).

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

41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6D at the point where the contract is signed or incorporated into the contract subsequently by 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 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 2022/23:

- with **providers of elective ophthalmology services**, setting out the steps the

provider will take to ensure that it responds appropriately to recommendations made in the report by the Healthcare Safety Investigation Branch on timely monitoring for patients with glaucoma. (Specifically, providers should be: risk rating patients; recording a recommended follow-up date (by completing the Earliest Clinically Appropriate Date field in relevant outpatient datasets) NHS Digital and NECT guidance on PAS; reporting compliance with the Portfolio of Indicators for Eye Health and Care follow-up performance standard (95% of hospital appointments to be within no more than an additional 25% of their intended follow up period, including rescheduling of hospital initiated cancellations); and addressing full implementation of failsafe prioritisation processes for follow-up patients, as described in Elective Care High Impact Interventions: ophthalmology).

- with **providers of acute services**, setting out the steps the provider will take to ensure full and ongoing compliance with UK Standard for Microbiology Investigations B37 by no later than 31 March 2023. This is important because standardised practice will help to reduce variation in service delivery and outcomes across the NHS in England. Improving blood culture pre-analytical pathway will result in both patient and Anti-Microbial Stewardship benefits and deliver the expectations of the Five-year National Action Plan for AMR, which states that all diagnostic laboratories should follow PHE SMIs for routine diagnostic work. SDIPs should focus on producing demonstrable Improvements by 31 March 2023, in performance against the key performance indicators relating to achieving collection to load times (where the standard is ≤ 4 hours) and to ensuring that adequate volumes of blood are cultured. As part of ensuring compliance, the provider must put in place appropriate sub-contracts with independent sector laboratories where applicable.

- with **all providers which employ registered nurses to deliver patient care**, to set out how the provider will roll out the accredited Professional Nurse Advocate (PNA) role across all clinical settings, with identified PNAs providing restorative clinical supervision and career conversations for nursing staff, in line with the Professional Nurse Advocate A-EQUIP Model.

- with **providers of mental health and learning disability services** to set out how the provider will support the STOMP (stopping over medication of people with a learning disability, autism or both) and STAMP (supporting treatment and appropriate medication in paediatrics) projects. Further information on STOMP and STAMP is available on the FutureNHS web site.

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

42 Managing activity and referrals

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

42.1 The key aims of the provisions in SC29 (Managing Activity and Referrals) are to ensure that:

- where patients have a legal right to choose their provider, this is always enabled;
- activity carried out under a contract is clinically appropriate;
- 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 CCG/ICB. And the provider can then offer the service to other CCGs/ICBs only as commissioned – that is, on the basis specified in the provider's contract with the first CCG/ICB. See paragraph 25.21 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 will be even more important in future, as ICBs and local partner Trusts will be under legal duties 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 a CCG/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 CCGs/ICBs. Clearly, it is ultimately for each CCG/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. CCGs/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, distinguishing between two categories:

- Category 1 Interventions – interventions which should not be routinely commissioned or performed, and for which an IFR, approved in advance by the commissioner, is always required; and

- Category 2 Interventions – interventions which should only be routinely commissioned or performed when specific criteria are met.

42.15 The Guidance is given contractual effect through provisions included at SC29.28-31. Note the requirement for the co-ordinating commissioner and the provider to agree clinically appropriate goals for the annual number of procedures in each category to be undertaken. The intention here is to encourage commissioners and providers to focus on this important issue, first through early discussion and engagement and then through ongoing monitoring. Material over-performance

against the activity goals in-year should prompt review and action to ensure that EBI policy is being fully implemented, but no individual patient should be prevented from accessing clinically appropriate treatment, in accordance with EBI guidance criteria, simply because the overall activity goal has been exceeded.

Overall responsibilities for managing referrals and activity

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

- Commissioners (SC29.3) (SC29.1 in the shorter-form Contract) must seek to ensure that referrals comply with any agreed protocols and (full-length version only) any relevant Activity Planning Assumptions. In practice, the reasonable expectation will be that commissioners should be making vigorous efforts to ensure that GPs and other primary care referrers are following agreed protocols.

- Providers (SC29.4) (SC29.2 in the shorter-form Contract) must also seek to ensure that referrals comply with agreed protocols. They will bear a particular responsibility for managing referrals which are internally generated (consultant-to-consultant referrals, say), but may also reasonably be expected to assist commissioners in ensuring that primary care referrals are in line with agreed protocols.

- Providers will also bear particular responsibility for ensuring that the decisions made by their clinical staff to provide treatment to patients are made in line with clinical thresholds set out the Contract or notified through Prior Approval Schemes. They must also seek to work within the Activity Planning Assumptions relating to referrals and other metrics.

NHS e-Referral Service

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

Any provider must hold a contract with an NHS commissioner (CCG/ICB or NHSE) 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 CCGs/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 CCGs/ICBs; these services will then be available to receive referrals from those CCGs/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/);

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

- subject to the detailed provisions (and flexibility for discretion) within the guidance referred to above, the commissioner will not be required to pay the provider for any first outpatient attendance which results from a non-e-RS GP referral.

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 Service Condition 29

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.

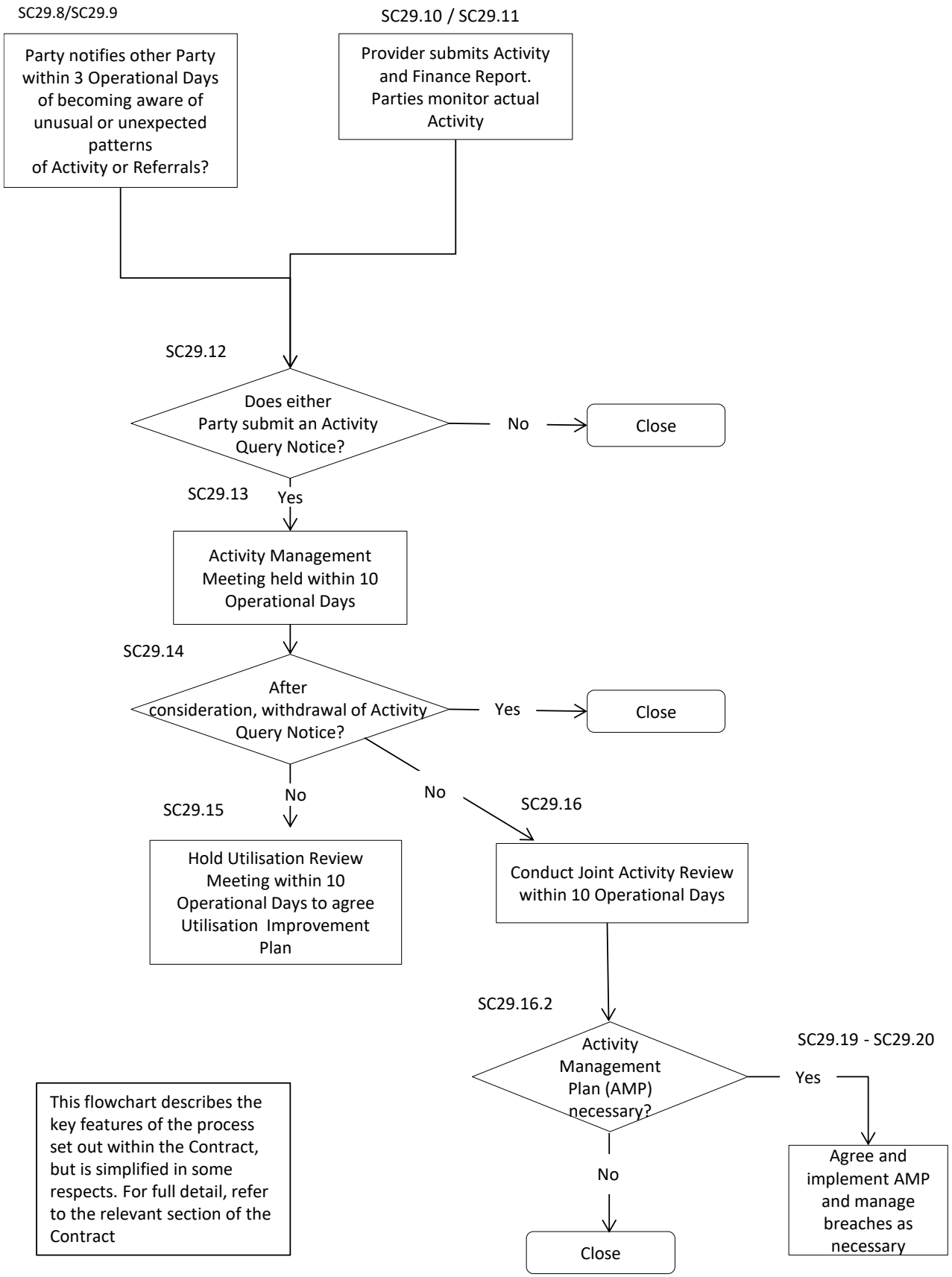
42.41 Exceeding the level of activity described in the IAP or breaching a ratio (or similar) set in an APA does not create an automatic entitlement for the commissioner to withhold funding. Rather, the contractual requirement is for an AQN to be served and an Activity Management Meeting to take place, 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 SC36.45 (see section 46), either on the basis of simple inaccuracy or because of failure to notify a locally-proposed change in the counting and coding of activity under SC28 (see section 44).

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



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) or of the national Evidence-Based Interventions Guidance (SC29.31).

43 Information, audit and reporting requirements

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

43.1 The Contract sets out a range of provisions relating to records and data, whether used for clinical or management purposes. Some of these are contained, for instance in SC23 (Service User Health Records), GC20 (Confidential Information of the Parties) and GC21 (Data Protection, Freedom of Information and Transparency).

43.2 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). (We have previously provided a separate appendix on information management and information governance. In the interests of brevity, we have discontinued this, although it remains available for reference in the 2020/21 Contract Technical Guidance.)

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 and set out on the NHS Digital website. Providers must submit data returns as appropriate for their organisation type and the services they provide from the list. This also includes the delivery of any data or definition set out in the NHS Digital guidance, and any Information 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 Despite the established principles above and the existing Contract wording which supports them in SC28, we receive consistent feedback about the high level of burden for providers which is generated by Local Reporting Requirements under the Contract.

43.6 As with Local Quality Requirements (see paragraph 39.7 above), commissioners are likely to find that a targeted approach with a limited number of well-chosen Local Reporting Requirements is the most effective approach. SC28.4 requires that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields. Particularly given the proposed new legal duties on ICBs and local partner Trusts 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 actually use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route.

Information Breaches

43.7 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.

43.8 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.

43.9 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.

43.10 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.

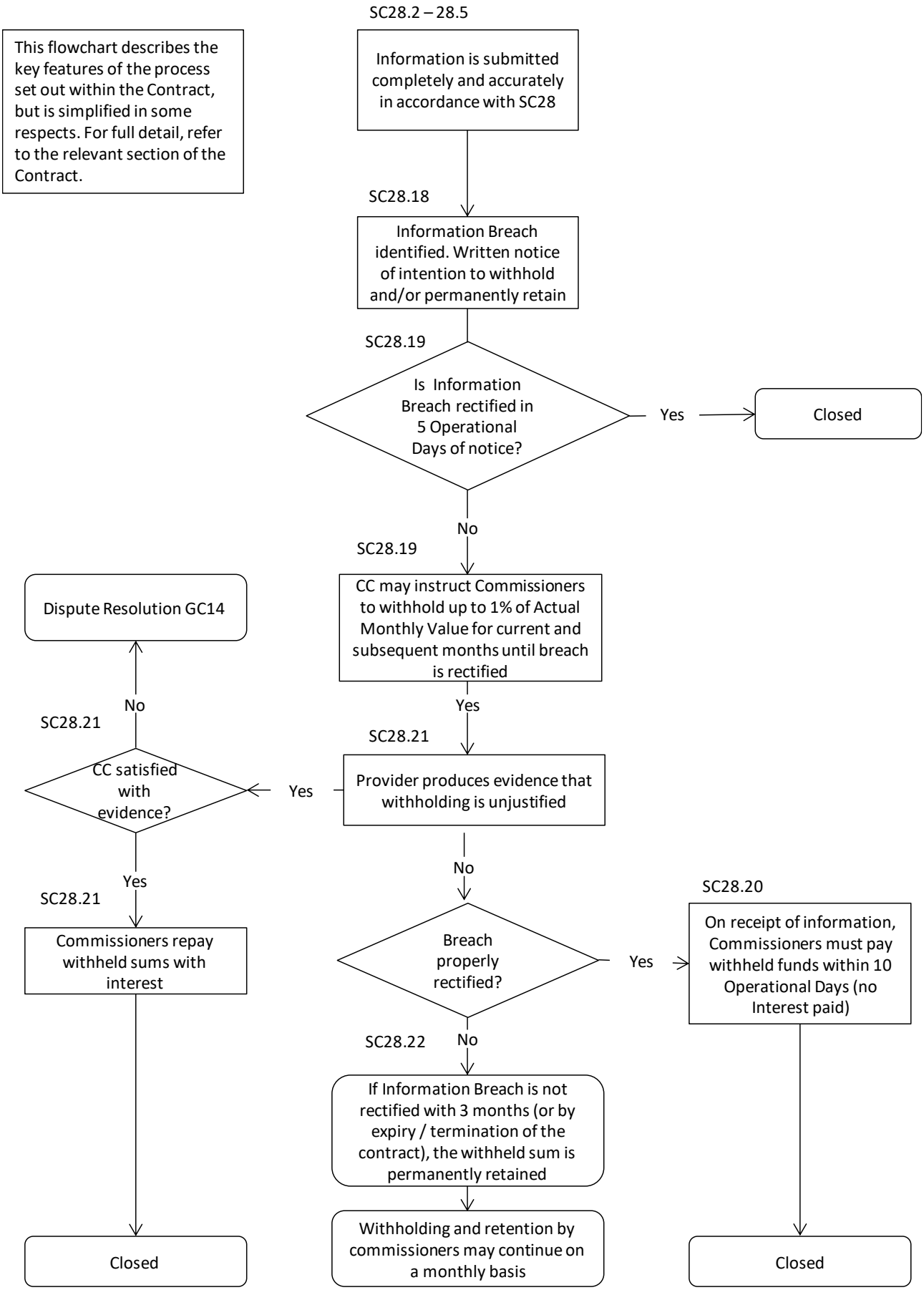
- In other cases, retrospective rectification may be impossible. If the data underpinning a reporting requirement has not been fully captured at the appropriate point in the care pathway (ambulance handover times, say), then the rectification is likely to focus solely on ensuring that data capture and reporting for the future is comprehensive.

43.11 The Information Breach withholding described above can be actioned by the co-ordinating commissioner on behalf of all the commissioners (see SC28.18).

SUS

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

SC28 (full-length contract) – Information requirements



Grey = updated from March 2021 Guidance Yellow = updated from draft Dec 2021 Guidance

Data Quality and Data Quality Improvement Plans

43.13 Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to meet the requirements of Schedule 6A and to support both the commissioning and contract management processes. Although completion of a DQIP is not mandatory for each contract, we nonetheless encourage commissioners to use DQIPs routinely to address data quality issues highlighted through direct reporting at point of submission or through NHS Digital's Data Quality Maturity Index (DQMI).

43.14 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.

43.15 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.

43.16 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.

43.17 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).

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

- The NHS Digital monthly SUS data quality dashboard provides benchmarked evidence that commissioners should use to drive improvements in quantitative and process-based data quality indicators for admitted patient care, outpatients and Emergency Care data sets as well as for maternity and critical care. Each of the SUS Commissioning Data Sets are covered by the DQMI.

- Other data quality reports are published by NHS Digital relating to national data collections including the Mental Health Services Data Set, the IAPT Data Set, Community Services Data Set and Diagnostic Imaging Data Set. Each of these data sets is also covered by the DQMI.

- GC21.6 requires each provider to undertake audits of its performance against the Data Security and Protection Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality. In particular, Assertion 1.7 of the Toolkit requires providers to have in place policies and processes to assure the quality of their data. Guidance specific to this assertion has been developed to support this and covers many of the points discussed in this section.

- The DQMI is used across a number of different frameworks, including the Single Oversight Framework within the Digital, Data & Technology Dashboard of the Model Hospital and is collected by the Care Quality Commission as part of their Well-Led Domain. To ensure consistency across each of these and to assist in setting thresholds for the DQMI within DQIPs, NHS Digital has published guidance on its Data Quality web page.

43.19 DQIPs may be particularly useful where new national reporting requirements or datasets have been introduced and where providers are not yet routinely complying with these. This may be the case, for instance, with the Mental Health Services Data Set. Commissioners should therefore ensure that they monitor closely the data submitted by providers of the relevant services and consider whether use of one of the available contractual levers (DQIP or Information Breach) would be appropriate to ensure that any problems with the quality of data submitted by individual providers are swiftly rectified. In addition, a provider's level of performance against the Mental Health Data Quality Key Performance Indicators, as reported in the Mental Health Core Data Pack and the MHSDS Data Quality Dashboard, should be used by commissioners to determine whether a

DQIP would be appropriate and to guide its contents.

43.20 For 2022/23, commissioners are required to agree DQIPs

- **with providers of maternity services** to set out actions which the provider will take to improve the accuracy and completeness of its submissions to the Maternity Services Data Set v2 (MSDS v2.0). The DQIP should set out the actions which the provider will take to fully conform with Information Standards Notice DCB1513 (MSDSv2) as soon as possible. Key areas of focus within providers' MSDSv2 data submissions should be data fields covering continuity of carer, Personalised Care and Support Plans, Body Mass Index, complex social factors, and Clinical Quality Improvement Metrics (CQIMs) as published on NHS Digital's Maternity Services Dashboard to enable maternity services to assess their clinical care. Guidance on data required for continuity of carer, Personalised Care and Support Plans and CQIMs is available through NHS Digital's hub. Providers can improve their submission of this data by using the Maternity Services Dataset Data Quality Summary Submission Tool.

- **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 which are essential to support the planned introduction, measurement and monitoring of new standards arising from the Mental Health Clinically-led Review of Standards (more guidance on the key data items will be published by NHSE in due course);

  - 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 has been required for the last two years in relation to the provision of training for staff in the use of restrictive practices.

- **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.

- **with providers of community services** to set out actions which the provider will take – in line with the emphasis in the 2022/23 Priorities and Operational Planning Guidance and the legal requirement in this Data Provision Notice – to improve the accuracy and completeness of its Community Services Data Set submissions.

Audit

43.21 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).

43.22 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).

43.23 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. We have retained the provisions on counting and coding in the Contract for 2022/23, but we expect that – with the proposed new legal duties on ICBs and local partner Trusts to work together to deliver system financial balance – local disagreements about the financial impact of counting and coding changes should generally not arise. We will keep under review whether the detailed requirements 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 formal coding guidance from NHS Digital (which we refer to below as "nationally-mandated changes" and which are now covered in SC28.8-28.9); and

- changes proposed in order to comply with existing coding guidance from NHS Digital which is already in effect ("locally-proposed changes", covered in SC28.11-28.14).

44.3 The requirement to neutralise, in the short term, the financial impact of counting and coding changes applies to both categories. But there is a distinction between

the two categories in terms of the requirements around giving notice of proposed changes.

- The party putting forward a locally proposed change must do so by 30 September, for implementation on the following 1 April; whereas

- there is no requirement for the provider to give advance notice of a nationally-mandated change; all new NHS Digital guidance requiring such a change will be published on a publicly-accessible website, allowing commissioners direct access to the details and removing the necessity for notice. However, the provider must inform the commissioner when it commences implementation of new guidance.

44.4 SC28 makes clear that, ultimately, the need for, and extent of, any "neutralising" financial adjustment is triggered by the actual financial impact, in practice, of a counting and coding change, rather than solely by the impact which is estimated in advance, before the change is implemented. (This is made clear in SC28.9 and SC28.14.)

44.5 Local disputes over transactional issues such as these must be kept to a minimum, so that commissioners and providers can focus their efforts on more important matters relating to patient care. SC28.15 therefore requires the parties to work jointly and in good faith to monitor the actual impact of counting and coding changes and to agree the extent of any necessary financial adjustments.

Rationale for the national policy on counting and coding changes

44.6 For clarity, we have set out below the rationale for why the Contract must continue to contain requirements for the short-term neutralisation of the financial impact of counting and coding changes.

44.7 The National Tariff Payment System guidance does not itself set rules for how patient activity is to be recorded – these are contained in the NHS Data Dictionary published by NHS Digital. Rather, the Tariff guidance sets the basis on which recorded activity is to be grouped into different categories (e.g. healthcare resource groups (HRGs) for inpatient spells) and the prices which are to apply to those categories.

44.8 The national prices in the National Tariff (and under Payment by Results before that) have always been based on historic actual reference costs submitted by providers. So national prices are a product of:

- the historic actual costs of providing specific forms of patient activity; and

- the way in which providers have, historically, actually recorded that patient activity.

44.9 When each new national tariff is designed, the impact of changes to that design – such as the new grouping structure of HRG4+ for the 2017-19 tariff – is carefully modelled at national level, alongside other important factors such as inflation uplifts and efficiency requirements. This informs the eventual national prices, which aim to strike a reasonable balance between commissioners and providers.

44.10 For any national tariff to achieve its intended financial impact, it is fundamental that patient activity continues to be recorded on broadly the same basis that informed the calculations underpinning the tariff's development. Changes in recording practice could, under an activity-based payment system, have destabilising financial effects. For this reason, there have always been provisions in national guidance for managing changes in recording practice. These provisions were originally included in the PbR Code of Conduct and then, when that was discontinued in 2013, transferred into Service Condition 28 of the NHS Standard Contract.

44.11 The Contract provisions aim to strike a reasonable balance between

- on the one hand, promoting, in the medium term, accurate recording of activity in line with national data definitions, with providers being rewarded on the basis of accurately recorded activity data; and

- on the other, offering protection in the short-term, for commissioners and providers, against the financial impact of changes in the way activity is recorded.

44.12 We believe that it is essential that the short-term financial protection provided by the Contract provisions applies both to locally-proposed and to nationally-mandated changes, because neither can have been built into the national calculations for the setting of tariff prices described in paragraphs 44.6-44.9 above.

What do we mean by a counting and coding change?

44.13 The SC28 provisions relate to the counting and coding (that is, recording) of activity (that is, how Service Users are cared for or treated clinically under the contract).

44.14 In that context, a change in counting and coding practice is:

- a change from a previous, historically established way of recording activity which affects or would affect how or whether that activity is visible (i.e. reported) to the commissioner, through submission of datasets through SUS or other local reporting routes;

- a change which is systematic, in that it affects a group of patients in a similar way or ways, rather than just affecting an individual patient; and

- a change which may affect whether a certain activity is recorded at all or how it is recorded, in terms of how it is classified (as inpatient, outpatient etc.) and/or the extent of any detailed clinical coding of diagnoses and procedures.

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

Is this a change from historically established practice?

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

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

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

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

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

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

- If the provider has historically submitted the relevant datasets to SUS (or to the commissioner / CSU via another local route), then the commissioner has always been able to see the activity data for the clinic. All that has changed is that the provider has started to apply the national price. This is <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 National Tariff.

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

- Applying new Tariff arrangements without changing the way in which activity is recorded is one thing; making changes to how activity is recorded in order to increase, or with the effect of increasing, income under those new Tariff arrangements is another. The latter definitely does fall within the scope of the counting and coding provisions at SC28.

- The two examples below explain this further.

  - A national change such as the introduction of HRG4+ and the associated payment grouper does not, per se, fall within the requirement for financial neutralisation at SC28. HRG4+ is not about how patient activity is recorded in terms of activity classification and diagnostic and procedure codes; it is about how recorded activity is grouped and then charged for. The crucial difference is that the financial impact of HRG4+ has been allowed for, to the extent possible, as part of commissioner allocations and National Tariff setting – there is therefore no need for local adjustments to neutralise its impact.

  - By contrast, if a provider makes a change to its historically-established approach to the counting and coding of activity, in order to benefit financially from a change to the national structure of the tariff such as HRG4+, then that does qualify as a counting and coding change under SC28.

- Best Practice Tariffs are worth particular mention here. The whole intention of the national BPT approach is to give providers an incentive to adopt proven new approaches to service delivery. So, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a 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 2021 will be too late for implementation from 1 April 2022 (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 2022), with a consequent delay in potential implementation, if agreed, and full financial impact.

Nationally mandated counting and coding changes

44.33 NHS Digital makes available, in public, information about formal changes to requirements for clinical coding, activity recording and submission of datasets.

- Guidance on clinical coding, and Coding Clinic publications, can be accessed via the Resource Library page of NHS Digital's Delen system at https://hscic.kahootz.com/connect.ti/t_c_home/viewdatastore?dsid=356868&adv=S&showAllColumns=N&datViewMode=list&showSingleItem=N&shownum=10&startRow=1&sortCol1=Col_11&sortDir1=desc&sortCol2=Col_0&sortDir2=asc&sortCol3=0&sortDir3=asc;

- Information Standards Notices are published at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/information-standards-notices; and

- Approved Collections relating to the NHS Standard Contract are listed at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/nhs-standard-contract-approved-collections.

44.34 Since commissioners can access and view new guidance of this kind in the same way that providers can, the provisions of SC28 make it explicit that providers are not required to give advance notice to commissioners of their intention to implement changes to the counting and coding of activity as a result of specific, new formal guidance issued by NHS Digital (that is, a nationally mandated change).

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

44.36 Our understanding is that, for 2022/23, NHS Digital is planning only a limited number of updates to coding standards; these will be confirmed and published shortly in updated versions of the National Clinical Coding Standards ICD-10 and OPCS-4.9 reference books.

Neutralising the financial impact of counting and coding changes

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

44.38 What this means specifically is as follows.

For nationally mandated changes, the period of neutralisation is

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

For clarity, if the nationally mandated changes described in paragraph 44.36 above do have a financial impact locally, this must be neutralised until 31 March 2023.

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 2022/23, therefore, for locally proposed changes which are notified up to and including 30 September 2021:

- If a change is implemented with effect from 1 April 2022 or later, the financial impact is neutralised for the whole of the 2022/23 Contract Year.
- If a change is implemented before 1 April 2022, the financial impact is neutralised for the relevant part of the 2021/22 Contract Year and for the whole of the 2022/23 Contract Year.

44.40 Where a reasonable estimate of the expected impact of a change can be made in advance, the parties should make a provisional neutralising adjustment, at the start of the Contract Year, to the Expected Annual Contract Value. But, in all cases, the parties will need to agree a process for monitoring the actual financial impact of the change in practice. Where an estimated up-front adjustment has been made, this can then be amended to reflect the actual impact through the year – and where no up-front adjustment has been made and in-year monitoring establishes that there has been an impact, an adjustment (both retrospective and ongoing, as appropriate) can be made as a result. SC28.15 sets out a requirement for the parties to approach this jointly and in good faith.

Delays in implementing changes

44.41 When NHS Digital publishes new national guidance on activity recording or clinical coding, the expectation is of course that providers will implement this on the date or phased sequence of dates set by NHS Digital; indeed, doing so is a contractual requirement. However, we recognise that implementation by a particular provider may occasionally be delayed – advertently or inadvertently. If the provider realises, after the mandated implementation date, that it has not implemented the required change, can it still do so as a national-mandated change – or must it now give notice of its intention to do so as a locally-proposed change?

44.42 Equally, where a provider has given proper notice of a locally-proposed change, and the parties have agreed that it should be implemented on a certain date, then the provider is under a contractual duty to implement the change on that date. But if the provider nonetheless fails to implement the change to the agreed timescale, what is the consequence? Can the provider still proceed to implement the change later than agreed, or must it give notice again in the next annual cycle?

44.43 A simple rule of thumb applies in both these situations. If actual implementation is delayed but still takes place within six months of the intended implementation date (either as set out in NHS Digital guidance or, for locally-proposed changes, as agreed between the parties – in both cases, typically 1 April), then no further notice is required. If implementation is delayed beyond this point, the provider must notify the change (as a locally proposed change) by the next relevant deadline under SC28.11, and the period of financial neutrality will be extended accordingly.

Counting and coding changes for services with local prices

44.44 The provisions relating to counting and coding changes are of most relevance where services are being provided at National Prices. With services covered by Local Prices:

- the requirement for prior notification of proposed changes applies (so that neither party can be financially disadvantaged by application of an in-year counting change); and

- the impact of any proposed counting changes should be considered as part of the review of Local Prices for the following year, with the likely outcome being that the Local Price will be rebased to reflect the revised activity levels implied by the different approach to recording – this will have the effect of ensuring that any change is financially neutral.

What a provider should do if evidence of inaccurate recording emerges

44.45 There is inevitably a tension between the underlying requirement in SC28.7 that activity should be recorded correctly as required under relevant national guidance (the NHS Data Dictionary, for instance) – and the recognition, through the arrangements elsewhere in SC28 for locally-proposed counting and coding changes, that provider recording is, in practice, not always accurate. What does this mean for how providers should behave?

44.46 Technically, a commissioner could take the view that any instance of systematically inaccurate counting and coding amounted to an Information Breach by the provider, with consequences flowing in accordance with SC28.18-23. For the provider, therefore, the correct response on identifying such an instance is to notify the commissioner immediately of a locally proposed counting and coding change. By doing so, the provider is taking the appropriate action under the Contract to rectify the Information Breach, and the commissioner will therefore not be in a position to apply the financial sanction available for Information Breaches.

Implementation of local changes without prior notice

44.47 SC28.10 makes clear that providers must not implement local changes in counting and coding practice without prior notification and agreement. But if a provider nonetheless does so, what should happen?

44.48 Where a provider becomes aware only after the event that its staff have implemented a local change without proper prior notification of the commissioner, it must notify the commissioner at once, identifying the financial impact of the change as accurately as possible.

44.49 Similarly, if the commissioner is the first to become aware of such a change, it should notify the provider and, to protect its position, should contest payment for the financial impact of the change (as accurately as it can reasonably assess), at the earliest opportunity, under the arrangements for financial reconciliation at SC36. (Remember that a commissioner contesting payment under SC36.45 must always give its reasons "in reasonable detail"; so the commissioner should, in such an instance, set out to the provider proper evidence that a counting and coding change has taken place and that it has had the direct effect of increasing commissioner payments.)

44.50 In either case, because the provider has not given proper notice, the commissioner is likely to be justified in challenging payment in respect of any adverse financial impact for itself of the revised recording basis. This will apply both prospectively (until such point as proper notification of the change has taken place and the necessary period of financial neutrality has been enforced, as required under SC28) and retrospectively (to the date at which it contested payment under SC36.45).

44.51 If an un-notified counting and coding change is identified only well after its implementation, the question then arises as to whether the commissioner can properly seek retrospective financial protection back to the date of implementation, even if this pre-dates by some months the point at which the commissioner contested payment. Two points are relevant here.

- The wording on financial neutrality in SC28.9 and 28.14 now includes a reference to changes "found following implementation to have had" a financial impact. The intention of this wording is to ensure that neutralising financial adjustments are based on the actual impact of the change, not just on an in-advance estimate which may prove inaccurate. The wording of SC28 does not, however, create an automatic entitlement for a commissioner to receive

financial redress for an un-notified counting and coding change back to the point of implementation.

- The provider may of course offer such retrospective redress voluntarily, but – if not – the commissioner may instead seek it using the provisions of GC11.2 (Liability and Indemnity). These provisions of GC11 allow either party to claim redress for losses it may suffer as a direct result of the other party's negligence or breach of contract. Note, however, that GC11.12 requires the party seeking to make such a claim to "take all reasonable steps to minimise and mitigate" its losses – so, for a retrospective claim under GC11 to be successful, a commissioner is likely to have to demonstrate that it has been vigilant in identifying and contesting the un-notified counting change at the earliest reasonable opportunity.

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

44.52 Counting and coding changes are not always easy to identify or assess. There can be local disagreements over whether an un-notified change has actually taken place and over what the impact of a change (notified or un-notified) has been. This is particularly true where the issue relates to a gradual increase in the acuity of reported inpatient casemix, for instance, with an associated increase in the depth of diagnostic coding at episode level.

44.53 There are two important points here.

- Firstly, an un-notified counting and coding change is easiest to detect where it is a step-change – that is, for instance, where a provider reclassifies activity as daycase rather than outpatient. A change of this kind will usually be readily apparent from a straightforward analysis of commissioning datasets. However, a gradual but sustained change – for example, an increase over a year in the average number of diagnostic codes per episode in a particular service from three to four – may also be a counting and coding change. A counting and coding change does not have to be an "overnight" step-change.

- However, a reported increase in depth of diagnostic coding may have many potential explanations. A counting and coding change may be one (or indeed the only) factor in some cases. In other cases, an increase in reported casemix complexity for one commissioner may be explained by planned service developments / pathway changes or changes in patient flows between providers, change in attribution of patients between CCG/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 NHS Digital's standards and guidance.

44.57 By contrast, an audit under GC15 may appropriately be instigated by the commissioner as a way of assessing whether an un-notified counting and coding change has indeed taken place and what its financial impact has been. But, in such cases, it is essential that the audit is set up and undertaken as GC15 intends – with the Auditor acting as "an appropriately qualified, independent third party" (as the Contract definition in the General Conditions describes it), with a duty to establish the factual position impartially and objectively, taking into account all reasonable evidence and arguments. The role of the auditor under GC15 must not be confused with that of an external consultant to the commissioner. The auditor's role is emphatically not to provide the commissioner with advice on how best to interpret the evidence to its advantage; rather, GC15 must be used with the aim of providing the local parties with a "single version of the truth" from an authoritative, impartial source, albeit one appointed by the commissioner.

Conclusion

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

45 Contract management

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

Contract review process

45.1 The contract review process is set out in GC8 (Review).

45.2 The necessary frequency of reviews will generally depend on the subject matter and size of the contract and the level of financial or clinical risk involved. The parties may agree a suitable interval between reviews, which should be at least every six months. The review frequency agreed should be set out in the Particulars. (Under the shorter-form Contract, we expect review meetings to be held as and when required, rather than on a fixed schedule.)

45.3 The matters for review will depend on the type of contract. Potential areas for review will include service quality, finance and activity, information, and general contract management issues. Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the quality and Information schedules.

45.4 Either party may call an emergency review meeting at any time. Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.

Contract management process

45.5 The stages of the contract management process are set out in the flowchart 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 and improvements to be achieved and maintained, with the RAP setting out required timescales for each.

45.12 Clearly, the intention of a RAP is that it leads to remedy of the contractual obligation that has been breached. But the Contract sets out provisions which apply where this is not the outcome.

- By agreement, a RAP may include reasonable and proportionate financial consequences (on either the provider or the commissioners) which are to be applied where the actions / outcomes set out in the RAP are not undertaken / achieved as the RAP requires. Where this is the case, these financial consequences may be applied immediately the breach of the RAP is clear. No Exception Report is required in order for these financial consequences to be exercised.

- Alternatively, where no immediate financial consequences are agreed as part of the RAP itself and where the provider breaches the RAP, the co-ordinating commissioner has the opportunity under GC9 to issue an Exception Report. The co-ordinating commissioner may at this point withhold funding ("a reasonable and proportionate sum of up to 2% of the Actual Monthly Value" in respect of each action not completed or improvement not met, "subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value"). Following issue of the Exception Report, the Contract then allows the provider a further 20 Operational Days to resolve the breach of the RAP. If the breach remains unresolved at this point, the co-

ordinating commissioner may permanently retain, at its discretion, the sums it has previously withheld.

45.13 The intention of these provisions is a) to emphasise that financial consequences should be reasonable and proportionate and b) to create a greater incentive for specific, appropriate financial consequences to be agreed between the parties as part of RAPs, rather than encouraging reliance on the broader provisions for withholding of up to 2% of Annual Monthly Value.

45.14 These broader provisions for withholding funding under GC9 are deliberately available to the commissioner only – since the priority here is to protect services to patients, which it is the provider's role to provide. But note the following.

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

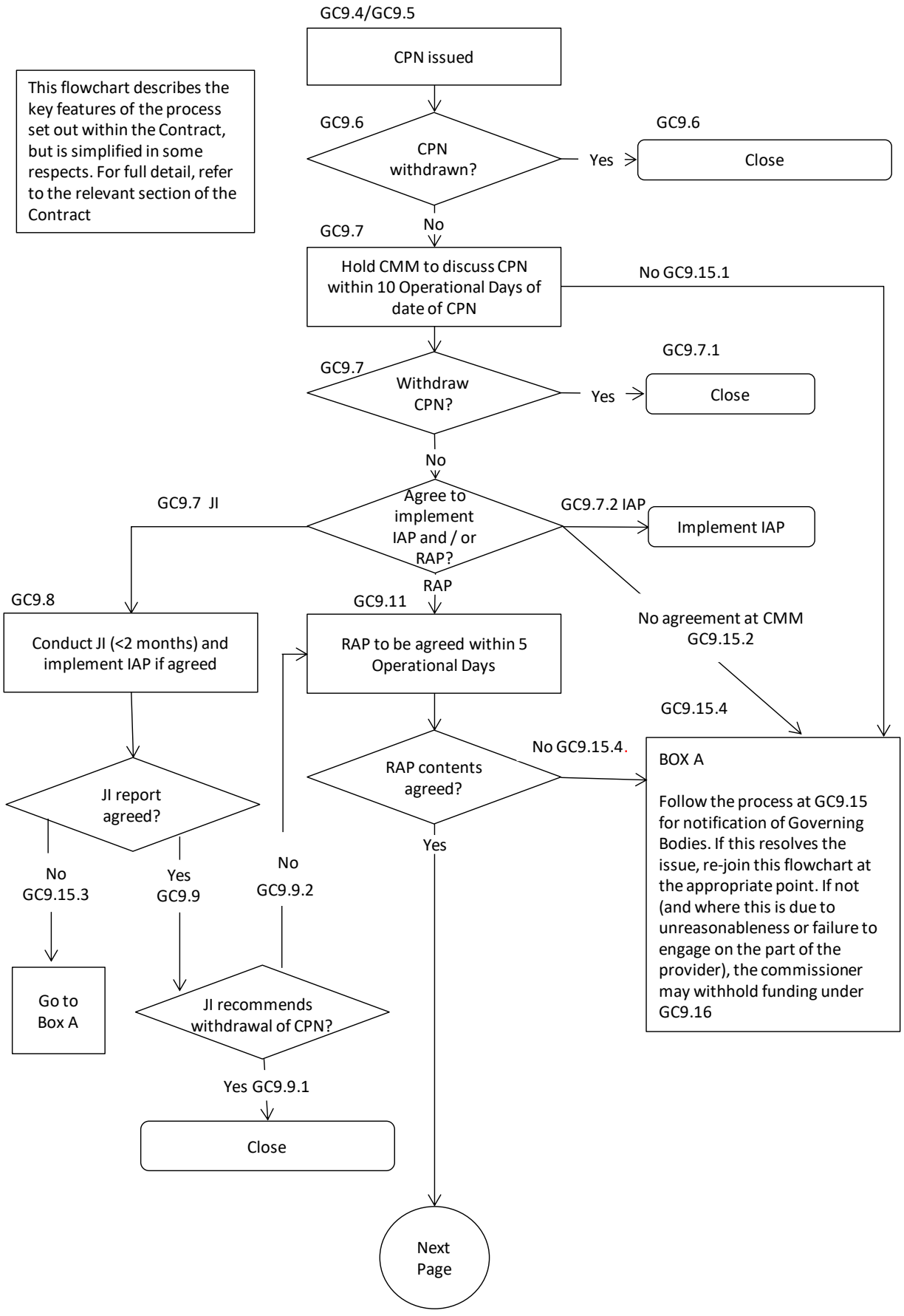
- Funding is withheld temporarily in the first instance and is repayable to the provider, once the provider engages properly in the remedial process (if the withholding is under GC9.16) or fully implements an agreed Remedial Action Plan (if the withholding is under GC9.21). Funding may only be retained permanently by commissioners in the specific circumstances set out in GC9.22 or GC9.24-25.

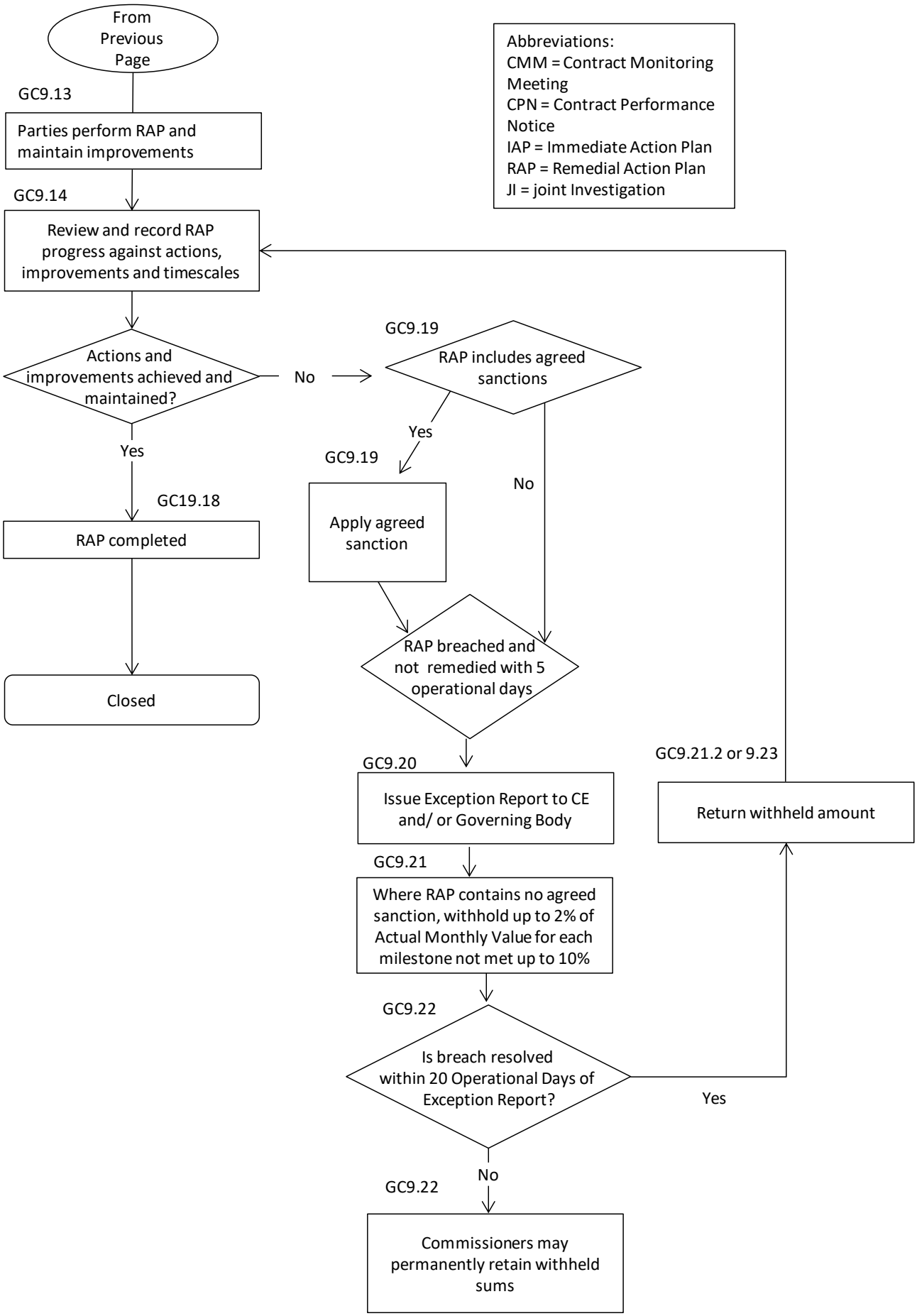
- Where a provider believes that a commissioner is refusing to address its own breaches of contract under GC9, it may a) pursue the matter through the dispute resolution process at GC14 and/or b) seek compensation under GC11 for losses which it can demonstrate that it has incurred as a direct result 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




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
GC9.19
RAP includes agreed sanctions
Yes
GC9.19
Apply agreed sanction
No
Yes
GC19.18
RAP completed
Closed
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 Agreed local details relating to payment are recorded in Schedule 3. Not all of the sub-schedules with Schedule 3 will need to be completed for every contract.

- Schedule 3A records Local Prices (including details of the basis on which payment is made for each locally-priced Service – Unit Price, unit price subject to locally-agreed modification, block payment, marginal rate etc). In the case of a contract covering more than one Contract Year, there is a specific provision (SC36.4) for the parties to record within Schedule 3A any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years.

- Schedules 3B and 3C record any Local Variations and Local Modifications.

- Schedule 3D records the agreed arrangements for those commissioner-provider relationships within a local contract to which the Aligned Payment and Incentive (API) rules (introduced under the National Tariff Payment System) apply.

- CQUIN is governed by the API rules. Schedule 3E records the detail of those commissioner-provider relationships within a local contract to which CQUIN applies and the relevant national CQUIN indicators which the provider is incentivised to achieve.

- Where API is not mandated for a particular contractual relationship, but where the local parties nonetheless choose to adopt some or all elements of the API approach, this should be set out in Schedule 3A (Local Prices), rather than in Schedules 3D (Aligned Payment and Incentive Rules) and 3E (CQUIN).

- Schedule 3F sets out the Expected Annual Contract Value (EACV). This is the figure on which any core contractual payment on account is based.

- Schedule 3G allows for recording of timing of payments in the first or final contract year.

The Contract does not contain a specific Schedule for the National Prices or Unit Prices published as part of the National Tariff Payment System. Where relevant, these published Prices will apply automatically – there is no need to record the actual prices in the local Contract.

Invoicing, payment and reconciliation

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

46.4 The arrangements were revised for 2021/22 onwards, with a change – in respect of reconciliation and retrospective invoicing – from a monthly process to, in most cases, a quarterly one.

46.5 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 SC36.25, 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, SC36.25 (SC36.21 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 commissioner QIPP 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 for activity actually undertaken. Where the provider is a Trust, such invoices are submitted quarterly – whereas, for non-NHS providers, the invoices are submitted monthly (the aim of this being to protect cashflow for smaller independent providers). 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

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

46.7 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 (SC36.28 to 36.31), with the provider submitting to the

commissioner both a first and a final reconciliation account, in accordance with the national SUS process and timeline.

46.8 Key deadlines from the SUS Submission Timetable for 2022/23, 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 2022	Thu 19 May 22	Wed 25 May 22	Tue 21 Jun 22	Mon 27 Jun 22
May 2022	Tue 21 Jun 22	Mon 27 Jun 22	Tue 19 Jul 22	Mon 25 Jul 22
Jun 2022	Tue 19 Jul 22	Mon 25 Jul 22	Wed 17 Aug 22	Tue 23 Aug 22
Jul 2022	Wed 17 Aug 22	Tue 23 Aug 22	Mon 19 Sep 22	Fri 23 Sep 22
Aug 2022	Mon 19 Sep 22	Fri 23 Sep 22	Wed 19 Oct 22	Tue 25 Oct 22
Sep 2022	Wed 19 Oct 22	Tue 25 Oct 22	Thu 17 Nov 22	Wed 23 Nov 22
Oct 2022	Thu 17 Nov 22	Wed 23 Nov 22	Fri 16 Dec 22	Thu 22 Dec 22
Nov 2022	Fri 16 Dec 22	Thu 22 Dec 22	Thu 19 Jan 23	Wed 25 Jan 23
Dec 2022	Thu 19 Jan 23	Wed 25 Jan 23	Fri 17 Feb 23	Thu 23 Feb 23
Jan 2023	Fri 17 Feb 23	Thu 23 Feb 23	Fri 17 Mar 23	Thu 23 Mar 23
Feb 2023	Fri 17 Mar 23	Thu 23 Mar 23	Fri 21 Apr 23	Thu 27 Apr 23
Mar 2023	Fri 21 Apr 23	Thu 27 Apr 23	Thu 18 May 23	Wed 24 May 23

46.9 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 (SC36.45A):

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

46.11 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 (SC36.28 and 36.30):

46.12 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.

46.13 The quarterly deadlines, in 2022/23, 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 25 Jul 2022	Tue 23 Aug 2022 plus five working days = Weds 31 Aug 2022
Quarter 2	Tues 25 Oct 2022	Weds 23 Nov 2022 plus five working days = Weds 30 Nov 2022
Quarter 3	Wed 25 Jan 2023	Thurs 23 Feb 2023 plus five working days = Thurs 2 March 2023
Quarter 4	Thurs 27 Apr 2023	Wed 24 May 2023 plus five working days = Thurs 1 June 2023

46.14 So, as an example, the initial reconciliation account for quarter 1 must be based on frozen SUS data for April and May (frozen at the monthly deadlines shown in the table 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 (frozen at the monthly deadlines shown in the table above).

Quarterly retrospective invoicing (SC36.35):

46.15 As described above, quarterly retrospective invoicing only applies for Trusts with no agreed EACV.

46.16 Whereas quarterly reconciliation is a two-stage process, quarterly retrospective invoicing happens only once per quarter. The provider must issue a quarterly invoice to the commissioner "within five Operational Days after the Final Quarterly Reconciliation Date" – that is within five working days of the Post-Reconciliation Delivery date in the table above. For quarter 1 of 2022/23, the deadline for invoicing is Tues 23 Aug 2022 plus five working days = Weds 31 Aug 2022. The same approach then applies in each succeeding quarter.

46.17 As with quarterly reconciliation, the quarterly retrospective invoice for, for example, quarter 1 must be based on frozen data for April, May and June (frozen at the monthly deadlines shown in the table above).

Monthly retrospective invoicing (SC36.35A):

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

46.19 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 above. For April 2022, the deadline for invoicing is Mon 27 June 2022 plus five working days – ie Mon 4 July 2022. The same approach then applies in each succeeding month.

Invoicing and reconciliation where SUS does not apply

46.20 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 SC36.25. However, the provider then only submits a single quarterly reconciliation account (SC36.31) – 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, invoices for actual activity undertaken must be submitted retrospectively – quarterly for Trusts (SC36.36), monthly for other providers (SC36.36A). In each case, the invoice must be submitted within 20 working days of the end of the relevant period (ie quarter or month as applicable).

Other points

46.21 Throughout SC36, the onus is on the provider to submit invoices and reconciliation accounts and on the commissioner to validate these, paying uncontested elements promptly in line with the timescales set out in the Contract and challenging any contested elements through the process set out in SC36.45. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.

46.22 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

46.23 The change to bring CQUIN, from 1 October 2021 onwards, within the scope of the API rules within the National Tariff Payment System has some important consequences.

46.24 CQUIN now only applies to those contractual relationships within scope of the API rules – that is, to

- all CCG/ICB-Trust relationships within the same ICS;

- all other CCG/ICB-provider relationships with an EACV of £30m or more; and

- all specialised services commissioned from providers by NHS England.

For instance, therefore, within a five-CCG/ICB contract with a Trust, there might be two individual relationships above the £30m threshold to which API and CQUIN apply – and three with lower EACVs to which API and CQUIN do not apply.

46.25 Note the following.

- The financial value of CQUIN remains at 1.25%, but it is now a proportion of the fixed element of payment – so it is no longer additional to the EACV, but rather a proportion of the EACV which is potentially at risk for the provider.

- The 1.25% value is to be paid in full to the provider in advance in monthly instalments as part of the EACV – so it is no longer necessary to negotiate separate arrangements for payment on account of CQUIN.

- One simplification in the new approach is that CQUIN applies only to the fixed element of payment agreed in the opening contract – there is no longer, therefore, any requirement to adjust CQUIN payments to reflect changes in actual activity levels.

- As previously, 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 3E. These arrangements remain set out in SC38 and continue to be managed by the Co-ordinating Commissioner on behalf of the other commissioners.

46.26 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.

46.27 The changes above to the applicability of CQUIN mean that CQUIN no longer applies to many contractual relationships with lower financial values, especially for instance those between CCGs/ICBs and smaller non-NHS providers.

- As a result, the National Prices and unit prices published as part of the 2022/23 National Tariff Payment System have been uplifted appropriately, to avoid any cost pressure to providers which were previously eligible to earn CQUIN.

- For contractual relationships governed by Local Prices (rather than by National Prices, the API rules or mandatory unit prices, as for example under the Increasing Capacity Framework), those Local Prices are of course a matter for local negotiation. But our clear expectation is that Local Prices should be agreed on such a basis that the change to the applicability of CQUIN will not cause a cost pressure for providers.

46.28 We have removed the previous Small-Value Contract exemption (under which commissioners could choose not to apply CQUIN in contracts with very low financial values), since it is no longer necessary. CQUIN is no longer referenced in the shorter-form version of the Contract (because we envisage that providers within scope of the API rules should always be commissioned using the full-length version), and CQUIN no longer applies to non-contract activity.

Charging overseas visitors and migrants

46.29 SC36.41 (full-length Contract) / SC36.21 (shorter-form) contains requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the Regulations and guidance governing this area.

46.30 Current DHSC guidance in this area, referred to in the Contract, is available at https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme. One important aspect of the recent changes is to require providers to receive advance payment for treatment from overseas visitors, except in the case of immediately necessary or urgent treatment, which should not be delayed. This in turn has knock-on implications for the financial arrangements set out in Improving Systems of Cost Recovery for Overseas Visitors. The effect is that the cost recovery arrangements described in paragraphs 46.31-33 below do not apply in situations where costs are recovered in advance or at the time the care is provided.

46.31 In summary, in those situations where overseas patients are liable to charges, under the new regime, providers are to charge 150% of the tariff or local price for the relevant treatment. Commissioners are to pay at 75% of tariff or local price pending recovery from the overseas patient. If payment is recovered, the provider will refund that 75% payment to the commissioner and retain the balance; if it fails

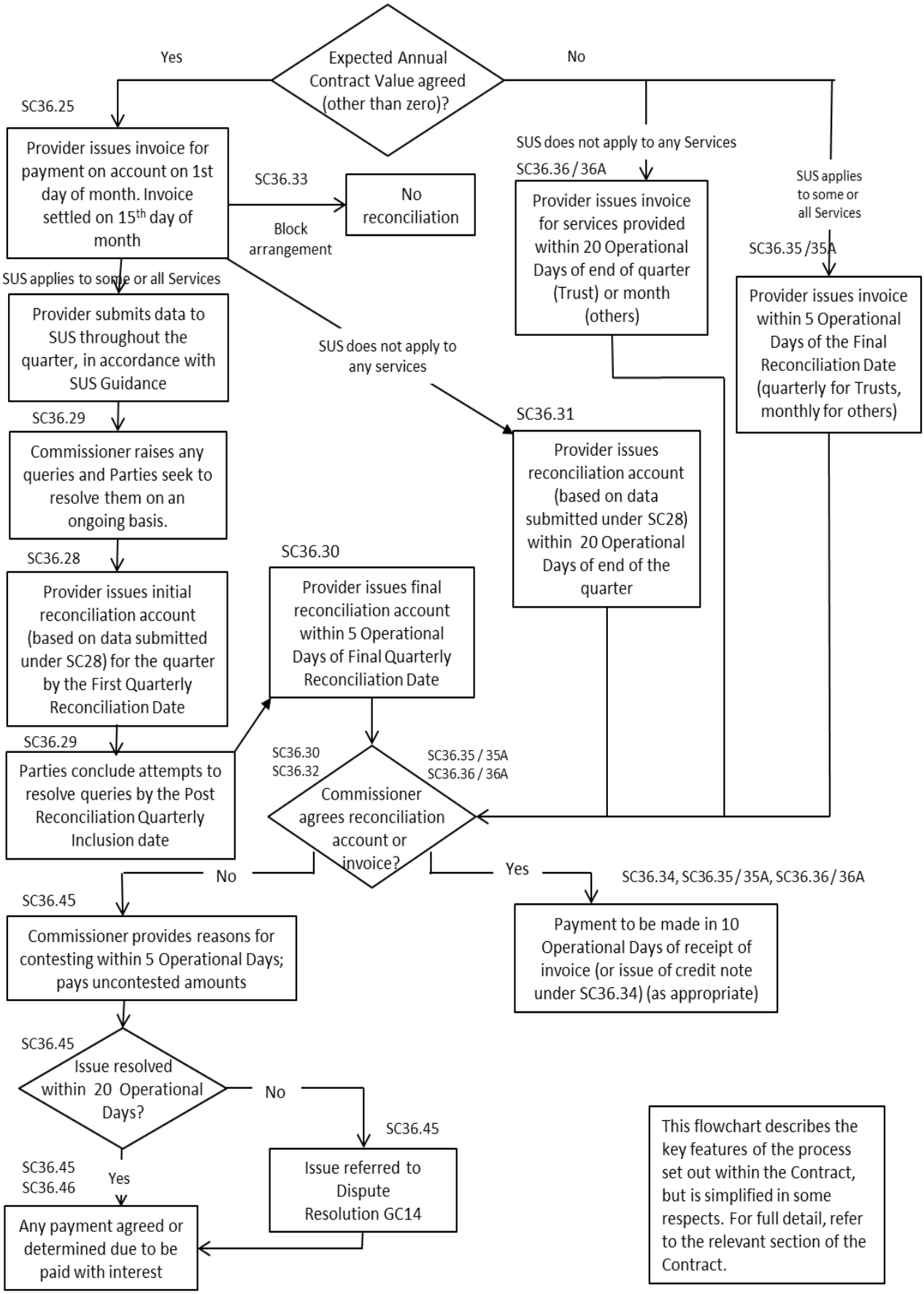
to recover payment from the patient, liability for the cost of treatment (at tariff or the agreed local price) is effectively shared 75% / 25% between commissioner and provider.

46.32 If, however, the provider fails to take appropriate steps to identify an overseas visitor liable to charges for NHS services, or fails to take reasonable steps to recover payment, liability for cost of all chargeable treatment for that patient falls on the provider.

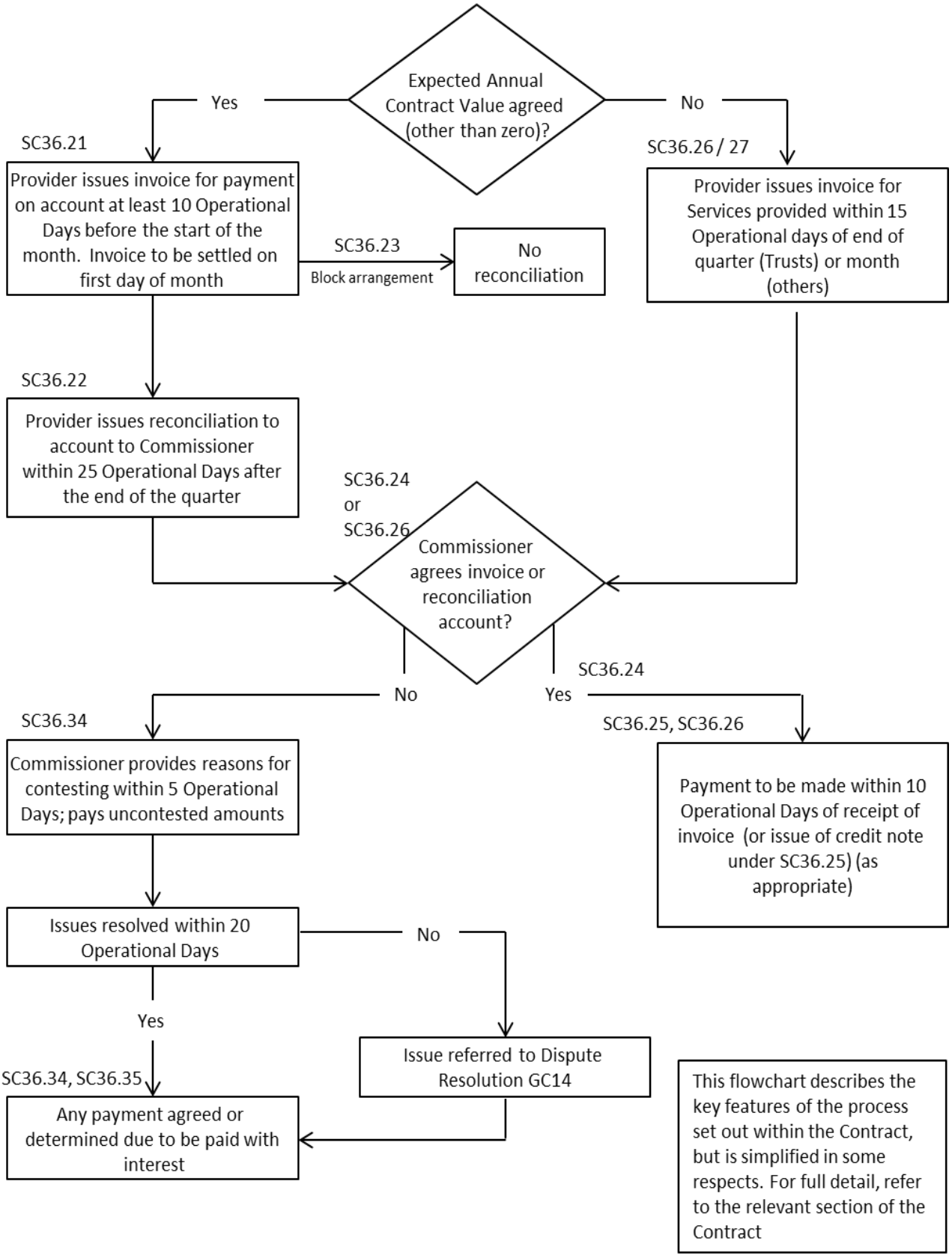
46.33 It may often take some time for providers to recoup charges from overseas patients – or for patients to provide definitive evidence that they are exempt from charges. It will therefore generally be sensible for commissioners and providers, by local agreement, to apply the reconciliation timescales set out in SC36 in a more flexible way in respect of such patients. This will allow more time for the correct payments to be assessed and made – enabling providers to make the 75% refunds to commissioners described above, or to apply the full 100% charge to the commissioner in a situation where a patient has, after some delay, confirmed their charge-exempt status.

46.34 Resources for NHS Trusts to help manage overseas visitors and migrant charging have been published by the Department of Health and Social Care and are available at https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants?

SC36 (full-length Contract): Payment and Reconciliation



SC36 (shorter-form Contract): Payment and Reconciliation



47 Other contractual processes

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

Variation

47.1 Arrangements for varying 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 3.19-23 above, for 2022/23 onwards, the GCs and SCs will 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. As explained in paragraph 2.5 above, NHS England will publish one final National Variation, so that 2021/22 contracts can be updated to reflect changes to the national terms for 2022/23.

47.3 Commissioners and providers may of course also agree locally initiated 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 15 above.

47.4 There is no specific period of notice which must be given for locally initiated Variations. Rather, the agreed timescale for implementation should be set out in the Variation Agreement and should reflect the complexity of the issues involved and the time realistically needed to implement the specific changes proposed – and, of course, when the parties wish the changes to take effect.

47.5 Acceptance of a locally initiated Variation by the provider cannot be compelled – but, where such a Variation is refused, the commissioner has the option to terminate, with notice, the specific Services affected (GC13.14) (or, in the case of the shorter-form Contract, to terminate the Contract altogether under GC17.2).

47.6 Whenever a contract is being varied, the parties must ensure that they use, as the starting point for that Variation, the latest version of the contract (which may be the original contract or the contract as most recently updated by a signed and dated Variation Agreement). Parties to a contract should not progress more than one Variation to it 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 any equivalent provisions which may be included in the proposed future NHS Provider Selection Regime. The parties should seek their own legal advice before proceeding with any Variation which might be caught 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 has been signed. 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 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. GC17.10.6 (GC17.5.6 in the shorter-form Contract) gives the commissioner a specific right to terminate the contract without notice where, in relation to a personal data breach connected to the Services, i) the Information Commissioner's Office (ICO) takes specific enforcement action or ii) the provider or a member of Staff is found guilty of / pleads guilty to a criminal offence.

Consequences of expiry or termination

47.22 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. Note that NHS Resolution has recently published helpful guidance for NHS commissioners of clinical services seeking to ensure that providers with which they are proposing to contract have in place adequate indemnity arrangements.

47.34 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, added, as GC11.8 (GC11.5 in the shorter-form Contract), a requirement to support that existing obligation to ensure that "run-off" cover is in place. The provider must provide evidence that this cover is in place, and if it fails to do so the commissioners may put cover in place themselves (which they would do by paying the appropriate additional contribution to NHS Resolution for CNST / CNSGP cover) and charge the provider for the costs they incur in doing so. This is to address concerns that a provider may go out of business following expiry or termination of a contract, leaving "uninsured" potential claims for its clinical negligence, and both Service Users and the public purse therefore at risk.

48 Status of this guidance

48.1 This Contract Technical Guidance is intended to support commissioners in using the NHS Standard Contract and sets out clear expectations for how certain aspects should be addressed. 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.

	As explained in 3.19-23 above, we are proposing that, for 2022/23 onwards, the General Conditions and Service Conditions will exist online in their up-to-date form, as published by NHS England from time to time and will be incorporated in that 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.
	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.

	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'.	

Where a term in the contract is capitalised, this means that the term is defined in the definitions section at the end of the General Conditions. Text in red highlights where the position differs under the shorter-form Contract.

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

- text is entered in full into the relevant schedule itself, within the Particulars (this will work where the text is reasonably brief); or

- the schedule contains a reference to a separate document which is then appended to the contract as a separate attachment.

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

We are also asked about whether requirements which are not applicable to the services being commissioned may be deleted from the Particulars. 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 (CCGs/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 SC3.8 of the full-length Contract; definitions in the full length and the shorter-form Contracts	The name and contact details of the Provider's Nominated Individual must be inserted here (this will be the same person as the nominated individual for the provider's CQC registration, where relevant). The Nominated Individual will be the person responsible for supervising the management of the Services, and such an individual must be identified whether or not the Provider is required to be CQC-registered for the purposes of the Services to be delivered under the Contract.	
Provider's Information Governance Lead GC21.3.1, GC21.3.3, GC21.3.4	The name and contact details of the Provider's Information Governance Lead must be inserted here.	

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 SC6.11	The name and contact details of the Provider's UEC DoS Contact must be inserted here. (Not applicable to the shorter form)	
Commissioners' UEC DoS Leads SC6.12	The name and contact details of the Commissioner's UEC DoS Lead must be inserted here (CCGs/ICBs only). Insert additional blocks as required for the number of CCGs/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 Units (Use of Force) Act 2018 SC3.19	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 responsibility for overseeing its compliance with the Act – must be inserted here. (Not applicable to the shorter form)	
Contract 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 CCGs/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', here. This directory is updated monthly. All care homes in this directory are in the scope of the EHCH service model. The specific care homes in that directory in respect of which the provider in question is to be involved in delivering the EHCH service model are to be agreed locally and listed in Schedule 2Ai where indicated.	
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. See paragraph 3.13 above. (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 Part E as 'not applicable'. (The shorter form does not require a Continuity Plan to be included in the contract itself)	
F – Clinical Networks SC26	Set out here any Clinical Networks in which the Provider is required to participate. If there are no relevant clinical networks applicable to the Services, enter 'not applicable'. (Not included in the shorter form, but if the Provider is to be required to participate in a Clinical Network the appropriate details may be included in Schedule 2G.)	
G – Other Local Agreements, Policies and Procedures SC25	If there are specific local agreements, policies and procedures with which the Provider and/or Commissioner(s) are to comply, enter details of them here.	
H – Transition Arrangements GC4	The contract Transition Period is the time between the Effective Date and the Service Commencement Date. There may be certain things that need to be done during that period in order that services commence smoothly. Details of any such arrangements should be inserted here. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 1A and/or Schedule 2G.)	
I – Exit arrangements GC18.9	Where the parties agree specific payments to be made by one or more parties, and/or other specific arrangements which are to take effect, on the expiry or termination of the contract or termination 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 - Local Prices SC36.4 -36.10	Insert the detail of any Local Prices in Schedule 3A, entering text (or attaching documents or spreadsheets) which, for each separately priced Service: • identifies the Service; • describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template should be copied or attached; • describes any currencies (including national currencies) to be used to measure activity; • describes the basis on which payment is to be made (that is, whether (and if so how) dependent on activity, quality or outcomes, or a block payment); • sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s).	

B – Local Variations SC36.11 – SC36.15	For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required – or state Not Applicable. Additional locally agreed detail may be included as necessary by attaching further documents or spreadsheets. Any "locally agreed adjustments" (under rule 3 of the Aligned Payment and Incentives Rules) should also be included here.	
C – Local Modifications SC36.16 – SC36.20	For each Local Modification Agreement (as defined in the National Tariff) which applies to this contract, copy or attach the completed submission template – or state Not Applicable. For each Local Modification application granted by England, copy or attach the decision notice published by NHS England. Additional locally agreed detail may be included as necessary by attaching further documents or spreadsheets.	
D – Aligned Payment and Incentive Rules SC36.3, SC36.21	Where the Aligned Payment and Incentives Rules apply, insert details as agreed locally for each relevant Commissioner, as shown in the Schedule itself.	
E – CQUIN SC38	Where the Aligned Payment and Incentives Rules apply, include here the relevant national CQUIN indicators, in accordance with National Tariff Payment System Guidance and CQUIN Guidance.	
F - Expected Annual Contract Values SC36	Insert the total Expected Annual Contract Value (EACV) for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). The EACV must not be seen as an upper or lower cap on the provider delivering choice services. Where there is no EACV, enter 'not applicable'.	
G – Timing and Amounts of Payments in First and/or Final Contract Year SC36.26, SC36.27	If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here. Where the first and final Contract Year is 1 April – 31 March, enter 'not applicable'. (Not included in the shorter form, but if necessary appropriate provisions may be included in Schedule 3A.)	
Schedule 4 – 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	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 all, or for some specific, purposes under the contract. The roles and responsibilities must be set out in the separate Collaborative Commissioning Agreement document entered into by all the Commissioners who are parties to the contract. (Not included in the shorter form.)	
Schedule 6 – Contract Management, Reporting and Information		
A - Reporting Requirements SC28	This table is used to set out the information that is required to be reported under the contract. See also paragraph 43 above.	
B - Data Quality Improvement Plan (DQIP) SC28.24 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 must be included. (Not included in the shorter form.)	
C – Incidents Requiring Reporting Procedure SC33	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.	
D – Service Development and Improvement Plan SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 41 above, which sets out certain situations in which an SDIP must be included. (Not included in the shorter form.)	
E – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys. (Not included in the shorter form.)	
Schedule 6F – Data Processing Services ***Note: the Provider Data Processing Agreement has been moved to 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. Complete this Schedule 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 6F will need to be added manually to the local contract where required. For	

	this purpose, a separate Schedule 6F (including the Provider Data Processing Agreement itself) has been published at https://www.england.nhs.uk/nhs-standard-contract/22-23/	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 47.35 above.	
Schedule 8 - TUPE		
TUPE	Applicable to the shorter form only. It may in certain circumstances be appropriate to omit the text of this Schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.	
Schedule 8 – Joint System Plan Obligations		
Joint System Plan Obligations	This optional schedule may be used to set out actions which the commissioner and provider have agreed to take through their Joint System Plan. These actions may be to improve the provision of services under this specific contract or to ensure that services provided under this contract integrate with and support those provided by other organisations within the local health system. Further detail is provided within the Schedule itself. (Not included in the shorter form)	

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 CCG/ICB-commissioned inpatient mental health services should be followed up within 72 hours. This applies to everyone who is discharged from a CCG/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 a CCG/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%.

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

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

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