Guidance on the NHS Standard Contract 2012/13

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Document Purpose	Best Practice Guidance
Gateway Reference	17063
Title	Guidance for the 2012/13 NHS Standard Contract
Author	Department of Health
Publication Date	22 Dec 2011
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Directors of Finance, GPs, Communications Leads, Directors of Children's SSs, Independent Sector, Voluntary, Charitable and Social Enterprise Sector Organisation
Circulation List	
Description	This document contains the guidance 2012/13 NHS Standard Contract
Cross Ref	The Operating Framework for the NHS in England 2012/14
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	NHS Standard Contracts Team Room 166 Richmond House 79 Whitehall London SW1A 2NS 0207 210 5134
For Recipient's Use	

First published December 2011
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Guidance on the NHS Standard Contract 2012/13

Contents

Executive summary

This document provides guidance to support implementation of the 2012/13 NHS Standard Contract.

It describes the key changes from previous versions of the NHS Standard Contract, provides an explanation of key contract clauses and offers guidance on completion of the main contract schedules.

The 2012/13 NHS Standard Contract should be used for acute hospital, ambulance, community and mental health and learning disability services. There are separate NHS Standard Contracts for high secure services and care homes.

1. Introduction

1.1 2012/13 represents the first of a two-stage process in the development of the NHS Standard Contract.

1.2 Bringing together the four core contracts and the two integrated services contracts into a single contract has allowed the contract to be restructured, the flow of clauses to be improved and the contract schedules rationalised.

1.3 During 2012/13 the second stage of the review process will allow the contract wording to be developed to reflect any changes arising from the Health and Social Care Bill which is currently making its way through the Parliamentary process.

1.4 The care homes and high secure services contracts will remain as separate contracts, with a view to merging these into the common standard contract in 2013/14. Rather than issue new 2012/13 contracts for these two service areas, national variations covering any changes to reflect the requirements set out in the 2012/13 Operating Framework will be published early in the new year.

1.5 This guidance document therefore covers acute hospital, ambulance, community and mental health/ learning disability services, although the principles will be relevant to other NHS funded services.

1.6 In addition to changes to clauses required as a result of merging the four contracts, the other main change to the contract for 2012/13 is the restructuring of the contract and the re-ordering of clauses into a more logical sequence. The core legal clauses have been moved to the end of the contract to allow greater focus on the services being commissioned.

1.7 The 2012/13 Operating Framework makes clear that emerging CCGs should play an active role in the planning round for 2012/13, taking ownership of those parts of a PCT cluster's plans that it will inherit. The guidance for commissioners in this document should be read and interpreted in that context.

1.8 The involvement of local clinicians in the 2012/13 contracting round is essential, as PCT clusters will be mindful that contracts with providers of NHS funded services must transition smoothly to CCGs, the NHS Commissioning Board or local authorities.

1.9 This document is intended to support commissioners in implementing the contract and should not be viewed as an interpretation of the contract. In the event of conflict between this guidance document and the contract, the terms of the contract will prevail. **Appropriate legal advice should be sought as needed.**

2. What is the contract and how is it structured?

2.1 The 2012/13 NHS Standard Contract covers all agreements for all types of community and secondary care services between NHS commissioners, local authorities (where applicable) and providers of NHS funded care (ie acute hospital, ambulance, community, mental health and learning disability services).

2.2 Separate NHS Standard Contracts are available for care homes and high secure services.

2.3 The contract creates legally binding agreements between PCTs, local authorities (where applicable) and FT, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as set out in section 9 of the National Health Services Act 2006. The NHS Trusts will use exactly the same contract document and be treated with the same degree of rigour and seriousness as if the agreements were legally binding. Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding.

2.4 The contract is a standard, not a model, contract. Those parts of the contract which can be changed or modified are clearly highlighted within the contract documentation. There are three categories:

- Elements which are mandatory. These cannot be altered or removed, even by agreement of the contracting parties. These include the core legal clauses and definitions
- Elements which must be there but the details of which are for agreement or completion by the contracting parties. These elements must be fully completed as required to make the contract legally executable. These include the service specifications
- Additional elements which can be added by local agreement. There is no national or legal requirement to include these elements. Where contracting parties agree to include them, they cannot undermine any of the mandated or required elements. Examples include treatment protocols, additional local quality and information requirements and local incentive schemes

2.5 There are parts of the contract that may not be relevant or which are not applicable to the provider or the commissioner. Where this is the case, legal convention is that these sections are 'read over' (do not apply as they cannot apply).

3. Aims and principles

3.1 The standard contract provides a framework to hold providers to account for the delivery of high quality NHS funded services.

3.2 In using the contract, commissioners are expected to maintain a mature and regular dialogue with providers and act in an open and transparent manner. At all times the contract requires that commissioners and providers act reasonably.

3.3 Where the national Payment by Results (PbR) tariff does not apply, commissioners and providers will agree non-tariff prices, and where applicable, will be required to comply with the Code of Conduct for Payment by Results and with applicable Department of Health PbR Guidance.

3.4 Commissioners will be expected to behave in accordance with the Principles and Rules for Cooperation and Competition (PRCC). Any SHA-led commissioning 'rules' or requirements must also be consistent with these principles and rules.

3.5 The members of the Contract Stakeholder Reference Group agreed a set of guiding principles put forward by the Foundation Trust Network, the PCT Network and the Mental Health Network for the development of the contract, namely that it should:

- Reflect vision, long term planning and change
- Recognise the community interest
- Provide clarity on commitments that need to be made to stakeholders
- Clarify and define respective roles and responsibilities
- Recognise that open information is required to manage the contract
- Underpin a relationship between equals
- Understand mutual dependency and benefit of the parties in aiming for a partnership approach
- Support co-operation and collaborative behaviours that benefit all parties and cement the positive relationship between them
- Be based on terms that are deliverable in practice.

3.6 Stakeholders also agreed that the following behaviours are expected of providers and commissioners in their contractual relationship. They should:

- Find and support win-win solutions
- Achieve appropriate risk sharing, and sharing of any benefits that are realised by mutual effort
- Maintain mature, regular dialogue within a professional code of conduct
- Ensure flexibility where there are genuine problems in delivery
- Provide incentives as well as sanctions
- Recognise investment required to achieve requirements over a reasonable time period
- Support providers to change their service offer over time in relation to changes brought about through patient choices

- Maintain honesty and transparency – across both parties and with patients and the public

3.7 Emerging Clinical Commissioning Groups (CCGs) working with FT providers have identified a number of principles which it is felt should underpin successful service design and delivery in future. These are based on the over-arching principle that the purpose of the commissioning/ provider relationship is to improve the health of the population and that the patient voice must always be considered in dialogue and decision-making. These principles are:

- Services should be strategically designed to add value to patients and service users
- Discussions need to be clinically driven and informed by outcomes
- Innovations pursued should be from agreed information and data, supported by a clinical evidence base where available
- Different cultures should be understood and respected
- Problems and issues should be proactively defined, surfaced and managed early in dialogue
- Mutual dependency needs to be understood and stressed
- Local flexibility is needed around including national contract levers

4. The contract, PbR and Patient Choice

4.1 The standard contract reflects requirements in relation to PbR and patient choice:

Payment by Results: the standard contract requires the parties to comply with the Payment by Results Code of Conduct and Guidance, where applicable http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131826

The contract supports the introduction of a national currency for mental health services. The PbR guidance explains how the national mental health currency will be implemented by 1 April 2012 and how the cluster should be used as the contract currency. As such, commissioners and providers may wish to align the service specifications with the clusters.

Patient Choice: the contract requires the provider to comply with the national requirements relating to patient choice and to use Choose and Book, where applicable to the services. Any new guidance relating to Choice should be implemented in-year.

The contract accommodates services commissioned on an Any Qualified Provider (AQP) basis to enable patients to have choice as to which provider they are referred to. Consideration should be given, where a provider is commissioned to provide services both on a non-AQP and AQP basis, as to whether a separate standard contract needs to be used for those services commissioned on an AQP basis. AQP services can be incorporated in the existing contract through a revised service specification and variations to the quality, activity, pricing and information schedules. FAQs relating to AQP and the contracts are available on the AQP Resource Centre: http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx

5. Agreeing the contract

5.1 Contracts and the appropriate national variations must be agreed between commissioners and providers of NHS funded care in accordance with the timeframe set out in the Operating Framework.

5.2 Commissioners and providers are required to agree service specifications for all services commissioned through the contract and relevant quality and performance standards.

5.3 Where contracts or variations to contracts have not been agreed, the parties should enter mediation and, if required, the formal disputes process set out within the existing agreements.

5.4 Any providers and commissioners who have not agreed a contract by 1 April will be unable to benefit from any of the contractual controls or protections that the contract provides, until they have concluded an agreement on its terms. For providers this means that they will be paid in arrears for activity undertaken, on receipt and clearance of invoices. For commissioners it means that applicable contract management mechanisms and performance requirements will be limited.

5.5 For contracts with an expiry date beyond 31 March 2012, any providers and commissioners who have not agreed the national variation, revised performance requirements or activity plans should use the mediation and disputes procedures set out in their existing agreements. Where the national variation is not agreed by the provider, the commissioners may issue a notice to terminate the contract with three months' notice. Any new contract subsequently offered will be the 2012/13 contract but in the interim providers will be paid in arrears for activity undertaken, on receipt and clearance of invoices. For commissioners it means that applicable contract management mechanisms and performance requirements will be limited.

5.6 The use of the NHS Standard Contract is not mandated for provider-to-provider subcontracting arrangements. However, where provider-to-provider sub-contracts are in place, the principal provider remains accountable to the commissioner for the performance of the overall contract and for the performance of their sub-contractors and it is therefore important that relevant requirements are flowed down into the sub-contractor contracts.

6. Parties to the contract

Co-ordinated commissioning

6.1 Good commissioning is central to ensuring the provision and delivery of high quality, cost effective services focused on the needs of the service users.

6.2 Co-ordinated commissioning allows commissioners to pool resources and realise economies of scale. Equally, one co-ordinated contract will be more efficient for providers of NHS funded care. Therefore, the co-ordinated approach remains the preferred approach.

6.3 In line with previous advice, co-ordinated commissioning must be used for all acute hospital services.

6.4 SHA clusters will determine the co-ordinating arrangements within their SHA. Other PCTs in the designated area whose patients use the acute provider will be an associate PCT for that contract.

6.5 This arrangement will minimise the administrative burden for both commissioner and providers.

6.6 As well as actively involving emerging CCGs in the development, negotiation and agreement of service contracts, PCT clusters should be supporting emerging CCGs in determining the most effective approach to co-ordinated commissioning arrangements for the future.

Local authorities

6.7 It is possible for local authorities to be a party to the contract, either as the co-ordinating commissioner or as an associate commissioner. Where a local authority is a party to the contract, the consortium agreement entered into between the associate PCTs and the associate local authority will be legally binding. Advice should be sought when drawing up the consortium agreement

Co-ordinating commissioners

6.8 The co-ordinating commissioner will have the following responsibilities:

- to negotiate and agree the contract with the provider to cover the requirements of its own service users and those of its ‘associate’ commissioners.
- to ensure that service specifications, prices and indicative activity plans are agreed with the provider.
- to agree the constitution of a consortium of associate commissioners and to ensure that all associate commissioners sign a consortium agreement that provides for clear governance and accountability.
- to act as lead on performance, contract management and other processes set out in the contract working closely with the other associate commissioners.

Associate commissioners

6.9 Associate commissioners will each develop their own indicative activity plan and payment schedule. Their main responsibilities are to:

- agree and sign a consortium agreement with other associates
- participate in consortium governance as required
- identify any specific care pathway or standard requirements which they wish to be accommodated by the provider and included in the service specifications
- pay the provider in accordance with clause 7
- participate in monitoring and review mechanisms as agreed with the co-ordinating commissioner.

Specialised commissioning groups (SCGs)

6.10 For 2012/13 SCGs will hold separate contracts for the services they commission. It is planned that SCGs will work together to co-ordinate their commissioning so that each provider should hold only one specialised commissioning contract.

6.11 The role of the SCG is essentially the same as that of a co-ordinating commissioner. For 2012/13 SCGs will agree contracts directly with providers on behalf of their member PCTs.

6.12 Where groups of SCGs agree to work together, to act as a consortium of SCGs, then a consortium agreement will need to be agreed by all the SCGs and relevant amendments to the establishment agreements will need to be made to allow SCGs to enter into associate arrangements.

SHA clusters

6.13 SHA clusters have a key role in overseeing the commissioning arrangements within their cluster. Their responsibilities are to:

- define the co-ordinated commissioning arrangements for providers in their region
- mediate in disputes between NHS Trusts and individual PCTs
- resolve disagreements between PCTs
- ensure contracts are signed within the required timescales
- ensure contracts meet national and local requirements before PCT signature
- ensure consistency of local agreements across the SHA, including the application of contract thresholds and consequences in line with the PRCC

7. Contract structure and main changes to the 2012/13 contract

Principal changes

7.1 The principal changes in the 2012/13 NHS Standard Contract are:

- merging the following standard contracts into a single contract
  - acute hospital services
  - mental health and learning disability services
  - community services
  - ambulance services
  - integrated acute/community contract
  - integrated mental health/community
- structural changes with a move from Particulars, Standard Terms and Conditions and Schedules to five contract Sections
- improvements to the flow of clauses
- incorporating the policy requirements from the 2012/13 Operating Framework. This includes updating of the section relating to quality and information requirements and Quality Incentive Schemes
- changes to the drafting as a consequence of merging the six contracts into one to ensure the contract requirements work across all service types
- changes to Activity Management and Planning to align the contract drafting following the publication of the *DH Response to the Cooperation and Competition Panel report on the operation of Patient Choice*:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131087

Contract structure

7.2 The 2012/13 contract is divided into five sections:

- Section A (the Particulars): a short contract document setting out the Parties to the contract and key dates.
- Section B (the Services): this section contains the key sections describing the services being commissioned and the quality and information requirements attached to these.
- Section C (Service Matters): this section contains a number of requirements/ conditions relating to the services being commissioned. It includes the conditions precedent, protocols and procedures relevant to the services and any consortium agreements
- Section D (Recorded Variations, Disputes and Change in Control)
- Section E (Core Legal Clauses and Definitions): This section contains the main legal terms and the definitions.

7.3 Annex One provides a summary guide to completion of the contract.

Key dates

7.4 The Particulars (Section A) include a number of key dates:

- Effective Date: the date the contract is signed by both parties
- Expiry Date: 31st March 2013
- Expected Service Commencement Date: the date on which the parties expect the service to commence
- Delayed Service Commencement Date: the actual date the service commences if this is later than the Expected Service Commencement Date
- Longstop Date: the date by which the services must commence for the Agreement to proceed
- Service Commencement Date: the actual date the service commences

Colour coding

7.5 The colour coding adopted in the earlier versions of the contracts has been retained for 2012/13. Within Sections A, B, C and D the 'red' elements are mandated elements which cannot be changed. The elements marked 'amber' are mandated for completion by the commissioner and provider through negotiation and are required for an executable contract. The elements marked 'green' are optional and are not required for an executable contract.

7.6 It is important to note that the Core Legal Clauses and Definitions must not be changed and therefore this section is only available as a PDF read and print file. Only those parts of the Particulars and Sections coloured amber and green may be changed and then only to the extent indicated in the text.

Clause translation tables

7.7 A 'Translation Table' detailing how clauses have moved between each of the 2011/12 contracts and the 2012/13 contract is set out in Annex two.

8. Contract duration

8.1 As last year, the contract has a standard duration of one year, with an automatic expiry date of 31st March 2013. The one-year default duration does not affect contracts entered into in previous years which have an expiry date beyond 31st March 2012.

8.2 As in previous years, it is recognised that there are a limited number of circumstances where the default duration may need to be varied.

8.3 Further guidance will be published early in the new year.

9. Service specifications

9.1 The service specification template is a mandated document and can be found in Section B Part 1. The specification should be used for all services covered by the contract.

9.2 Mandated and outline example service specifications can be found on the 2012/13 standard contracts web page.

9.3 Service specifications may be developed to describe services in a number of ways: by care pathways, by clusters (for mental health services), by individual service or by individual service user. For acute services, it is not generally expected that individual service specifications would be developed for each HRG.

9.4 There are six boxes in the service specification. Of these, five are mandatory.

9.5 In relation to the level of detail contained in the service specification, this should be proportionate to the services being commissioned. However, the service specification is intended to be a brief description of the services being commissioned and should generally be no more than four or five pages long.

9.6 The link between the service specification and quality and activity requirements and prices has been removed in the 2012/13 contract following stakeholder feedback as there had been some confusion as to what should be included in the service specifications and what should be included in the relevant contract schedules. For 2012/13 quality requirements, activity, prices and information requirements relating to individual service specifications should be set out in the relevant parts of Section B.

9.7 Sharing of locally developed specifications across SHA clusters and between clusters will allow for good practice to be shared across the NHS.

Completion of the service specification

9.8 Box 1 (Population Needs) should include a brief description of national and local population needs relating to the service together with any relevant information on evidence base. This should set the context for the service being commissioned.

9.9 Box 2 (Scope) will contain the key information relating to the service ie what are the objectives of the service, what is the service, how does it link into other services, is there any particular population base and any particular criteria relating to referrals.

9.10 Box 3 (Applicable Service Standards) should be used to list any national and local standards relating to the service- these are likely to be NICE standards or Royal College standards. It should be noted, however, that where these are intended to form part of the Quality Requirements, they should be inserted in Section B Part 8.1.

9.11 Box 4 (Key Service Outcomes) is intended to provide an overview of the key outcomes relating to the service. These should be 'headline' outcomes. Any associated performance indicators should be included within the Quality Requirements (Section B Part 8).

9.12 Box 5 (Location of Provider Premises) Premises should be listed where the location of the premises is considered to be a core component of the service being delivered. Where this is not the case this should be stated as 'not applicable.' For example, a commissioner may wish to list premises where there is a national provider of services operating from a number of sites, some of which may not have been commissioned by the NHS.

9.13 Box 6 (Individual Service User Placement). Completion of this box is non-mandatory but may be used where the service commissioned relates to individual named patients. In these circumstances, specific details of the placement should be listed here.

9.14 Within each of the six boxes, additional subheadings may be included.

Interface between specifications, quality requirements, prices and information requirements

9.15 As noted above, the service specification should contain a brief overview of each service being commissioned.

9.16 Any quality requirements relating to individual services should be inserted into Part 8 of Section B (Quality).

9.17 Prices relating specified services should be inserted in Part 6 of Section B (Non-Tariff and Reduced Tariff Prices)

9.18 Information requirements should be inserted into the relevant report detailed in Part 14 of Section B (Reporting and Information Management).

10. Quality

Context

10.1 'The NHS is moving to a system where quality and outcomes drive everything we do. The NHS Outcomes Framework is the catalyst for driving quality improvement and outcome measurement throughout the NHS': *The Operating Framework for the NHS in England 2013*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

10.2 PCT Boards should assure themselves that the services they commission meet appropriate levels of safety, quality and effectiveness, and take relevant action if they do not. Commissioners should also promote innovative practice that leads to improved quality and safety.

10.3 The *NHS Outcomes Framework 2012/13* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700 is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve.

10.4 The Outcomes Framework is designed to provide a national overview of how well the NHS is performing and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities. The indicators in the NHS Outcomes Framework cover the three areas of quality defined in the Health and Social Care Bill: clinical effectiveness, patient experience and patient safety.

10.5 *Liberating the NHS* proposed that the NHS Commissioning Board will in turn develop a Commissioning Outcomes Framework to assess the quality of the services commissioned locally by CCGs, in future (subject to the Health and Social Care Bill) in other words to translate the NHS Outcomes Framework into outcomes and indicators that are meaningful at local level.

10.6 The set of indicators in the Commissioning Outcomes Framework are likely to include:

- NHS Outcomes Framework indicators that are clinically and statistically significant when measured at CCG population level
- indicators based on NICE quality standards, which set markers of high quality, cost-effective care, covering the treatment and prevention of different diseases and conditions, and which are linked to the outcomes in the NHS Outcomes Framework
- indicators from other sources to ensure that all the NHS Outcomes Framework outcomes and improvement areas are measured, even where relevant quality standards are not yet available

NHS Commissioning Board Commissioning Outcomes Framework: An Engagement Document http://www.commissioningboard.nhs.uk/2011/11/29/cof/

10.7 The introduction of NICE quality standards and the launch of NHS Evidence in April 2009 support commissioners in the development of quality in both commissioning and contracting by bringing clarity to quality. NICE's authoritative, evidence based guidance describes what high quality care looks like for a pathway or procedure.

10.8 Underpinning commissioning, the registration requirements of the Care Quality Commission provide assurance of essential safety and quality levels for registered providers of health and social care. This is achieved through determining whether providers continue to meet registration requirements and, where they are not, taking action through sanctions and/or enforcement powers to secure compliance.

10.9 Medical revalidation is central to improving the quality and safety of care. NHS organisations must be ready in 2012 (as indicated by their organisational readiness self-assessment returns) with governance arrangements including appraisals for doctors (*The Operating Framework for the NHS in England 2012/13* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360)

10.10 In 2012/2013 PCT clusters will be preparing for the transition of commissioning responsibilities to CCGs, to the NHS Commissioning Board (in the case of directly commissioned services such as primary care and specialised services) and to local authorities (in the case of health improvement services). This should include the production of legacy documents detailing all quality initiatives. http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/NationalQualityBoard/DH_102954

Developing and measuring quality

10.11 As noted above, the three pillars of quality remain clinical effectiveness, patient experience and patient safety. In addition, the 2012/13 Operating Framework places greater emphasis on the use of patient surveys and actions taken in response to the findings.

10.12 In considering how quality is specifically included in the contracting process these domains should be borne in mind. Quality should be measured by the outcomes of care; both the clinical outcome and the experience of the patient, particularly as reported by the patient.

10.13 When moving to commissioning for outcomes, it is not always possible to commission change in the high level outcomes contained in the Outcomes Framework, for instance domain 1 ‘preventing premature deaths’. However, commissioning can aim for multiple outputs, such as reduced mortality following fragility fractures, which cumulatively will support the high level outcome in domain 1. Quality indicators should be used to support the achievement of these local outputs. In the future the Commissioning Outcomes Framework will help guide local commissioning for outcomes. In the meantime, commissioners can look at NICE's evidence and the indicators in the Outcomes Framework, with the existing data on outcomes for their population, to think carefully about where services might need to improve for the future. Improved services will help lead to improved outcomes.

10.14 The 2012/13 Operating Framework requires that attention should be given to commissioning for good basic care, including dignity and nutrition. An example service specification on 'Good Nutritional Care' will be available on the 2012/13 Standard Contracts web page within the DH site. Identifying and treating service users with, or at risk of, malnutrition will reduce unscheduled hospital admissions and reduce complications such as pressure ulcers. For inpatients length of stay, morbidity and mortality should also be reduced.

10.15 The 2011 National Quality Board publication 'Quality Governance in the NHS' is a useful guide to commissioning for quality.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125239.pdf

Monitoring quality (Section E Clauses 45, 46 and 47)

10.16 A Service Quality Performance Report should be produced for each month, as outlined in Section E clause 45 of the contract. The frequency of reporting will be defined in Section B Part 14.2 (National Requirements Reported Locally). As a minimum, the report should include a review of performance against Section B Part 8 quality requirement indicators and Section B Part 9 quality incentive scheme indicators.

10.17 Section E Clause 46 outlines the contract review process that should cover quality requirements, incentives schemes, the Service Development and Improvement Plan and other aspects of quality of service provision such as complaints, patient safety incidents, Never Events, investigations, HCAIs and care plan review and audit. Action to be taken if there are queries against performance is outlined in clause 47.

10.18 Any productivity measures agreed between the parties should be included in the Service Development and Improvement Plan (Section B Part 11).

Quality requirements (Section B Part 8)

10.19 As in 2011/12, the quality requirements have been divided into three elements. These are:

Part 1: Nationally mandated requirements which apply to all providers of relevant services and locally agreed requirements which local commissioners agree with providers

Part 2: Nationally Specified Events. These are events for which there is a defined national threshold and/or defined national consequence

Part 3: Never Events. This list has been updated since 2011/12. Guidance on Never Events was published in 2011 and should be followed in determining the level of any consequence.

10.20 The quality requirements should be agreed annually prior to the end of the contract year as set out in Section E Clause 6.5. Only in exceptional circumstances should these requirements be lower than those which they are to supersede. The Quality Requirements can be used to embed high quality care, achieved through the previous year's CQUIN or incentive scheme, as a baseline contractual requirement. Performance

against quality indicators should be included in the regular quality review (Section E Clause 46).

10.21 In choosing an area in which to set quality requirements the rationale for the choice should be explicit. This could vary from there being a national priority or a perceived local quality deficiency, or ensuring that a new service is being delivered as required in the service specification. Quality requirements should be set to aid achievement of the outcomes in the NHS Outcomes Framework.

10.22 In determining how quality requirements are measured the whole time span of the contract should be considered. It may not always be possible to utilise outcome measures initially or indeed to collect the information necessary for demonstrating the outcomes desired, therefore a developmental approach over the lifetime of the contract should be employed. This may mean that in the first year the quality indicator for a given quality requirement is the development and implementation of a relevant policy or the definition and establishment of collection methodology for new information requirements.

10.23 In the subsequent years, there might be an audit to establish whether specific aspects of service delivery have been achieved. This in turn may lead to more challenging requirements relating to clinical outcomes or patient experience being set against the known baseline, either as part of quality incentive schemes or as part of baseline, depending on the degree of challenge desired.

10.24 There are a variety of potential methods for measurement of quality indicators such as patient, carer or staff surveys (Section E Clauses 8.3 and 23.6), audit, service user visits, and complaints monitoring etc, as well as routine data collection.

10.25 In considering the data collection requirements associated with establishing quality indicators, the following issues should be discussed: is the data currently collected, can it be collected and how is it/could it be collected i.e. electronically or does it require manual collection. The resource implications of data collection should be considered. Data quality, such as timeliness, reliability, accuracy, verifiability and comparability, should be considered. In developing measurement processes, it is also important to consider if perverse incentives may be introduced into the system. Additionally the size of the organisation should be considered, to ensure that information requests are proportionate for the monitoring of the contract.

Never Events (Section B Part 8.3)

10.27 Never Events are serious patient safety events that are largely preventable. Guidance on the implementation and monitoring of the list is available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124580.pdf

10.28 The list of Never Events is included in Section B Part 8.3. In addition to any current reporting processes the providers will be required to record any Never Event as part of regular contract reporting.

Quality Performance Incentives Schemes (Section B Part 9)

10.29 All contracts are required to include the national incentive payment framework scheme, CQUIN. In addition commissioners may wish to define additional local quality incentive payments.

The Service Development and Improvement Plan (SDIP)

10.30 The SDIP is a mandated plan. The plans should be closely aligned to the commissioners' local commissioning plans and may include the following:

- productivity and efficiency plans agreed as part of the provider's contribution to local QIPP plans
- any agreed service redesign programmes
- service development plans
- any priority areas for quality improvement (where this is not covered by a Quality Incentive Scheme)

10.31 The SDIP should be agreed by the Effective Date ie the date the Agreement is signed by the parties to the contract. The size of the plan should align with the size of the contract.

10.32 The plan should be appended as Section B Part 11 of the contract. Progress against the plan should be reviewed through the contract review process (Section E Clause 46) and any issues addressed through the contract management process (Section E Clause 47). Where both parties agree changes, these should be recorded as a contract variation in the relevant schedule and the plan updated as appropriate.

10.33 In developing the SDIP the Parties should take account of the guidance on the behaviours to be expected of providers and commissioners in their contractual relationship. These were developed by the Contract Stakeholder Reference Group and are outlined in Chapter 3 of this guidance document.

10.34 In line with the principles outlined in Chapter 3, the parties to the contract should seek to share risk appropriately. In relation to productivity and efficiency targets and plans, these may need to be mapped out over the duration of the contract, being reviewed and updated as required on an annual basis.

Health Care Acquired Infections (HCAI) Reduction Plan

10.35 The HCAI Reduction Plan is a mandatory requirement for all service types. The plan should set out the provider's role in reducing infections, be this in a hospital or community setting. For an acute hospital provider, the HCAI Plan may be quite complex. For a small provider, the plan may be limited to ensuring clean equipment or washing of hands.

10.36 Progress against the plan should be monitored through the contract review process.

Provider Quality Accounts

10.37 Commissioners are statutory consultees of their providers' annual Quality Accounts, and can make use of this opportunity to assure themselves that there is shared understanding of each other's quality improvement priorities.

11. Quality incentive schemes

CQUIN payment framework

11.1 The provider's CQUIN scheme should be set out in Section B Part 9.2. The scheme should be re-negotiated on an annual basis using a variation made under Section E Clause 52 of the contract. Notwithstanding the exceptions set out below, it is expected that a single CQUIN scheme will be agreed for each provider, which will be reflected in each of the provider's NHS contracts.

Purpose of the CQUIN payment framework

11.2 The framework enables commissioners to reward excellence by linking a proportion of provider income to the achievement of locally agreed quality improvement goals, which should be set out in the relevant contract section. The framework aims to embed quality at the heart of commissioner-provider discussions, and to encourage a culture of continuous improvement amongst providers of NHS services. The provider's CQUIN scheme should consist of a set of ambitious but realistic goals for quality improvement and innovation, developed and agreed between commissioner and provider, with active clinical engagement.

11.3 The framework should be used in accordance with the NHS Operating Framework and the published guidance on using the CQUIN framework:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

11.4 A wide range of additional supporting resources is also available on the NHS Institute website:

http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin_schemes.html

CQUIN scheme value

11.5 CQUIN payments to providers are non-recurrent and on top of Actual Outturn Value. The financial value of the scheme is assessed annually based on Actual Outturn Value. For 2012/13, the financial value of the CQUIN scheme has been increased to 2.5% on top of the Actual Outturn Value (including tariff, non-tariff and cost per case income, together with the Market Forces Factor).

11.6 The expected value of the scheme should be calculated as a percentage of the estimated total outturn contract value for commissioned patient services. A convenient way to determine the expected value may be to use 2.5% of the value set out in the relevant contract section.

11.7 Where the contract is used by joint NHS and local authority commissioners, the CQUIN scheme should be agreed and documented as described. The financial value of the scheme should as a minimum reflect the proportion of the contract funded by the NHS.

However, the local authority commissioner may also decide to make part of its funding dependent on the scheme.

CQUIN scheme content

11.8 CQUIN schemes are not intended to cover comprehensively all service areas, but to focus on locally agreed priorities for ambitious improvement and innovation. CQUIN goals should require ambitious and progressive quality improvement year on year.

11.9 CQUIN goals are separate from, and must not duplicate, specific minimum expectations of providers set out in contracts, for example the performance and quality requirements. However, CQUIN goals should reflect priority areas outlined within the Operating Framework as well as local priorities. Commissioners and providers may use the opportunity to agree ambitious goals which go beyond national minimum requirements or which translate broad national priorities into specific local action.

11.10 In 2012/13, acute CQUIN schemes, including those agreed by Specialised Commissioning Groups, must again include the two national goals on reducing the impact of Venous Thromboembolism (VTE) and improving responsiveness to personal needs of patients. Commissioners and providers should refer to detailed guidance on the national goals.

11.12 There are two additional national goals for 2012/13 covering the use of the NHS Safety Thermometer (applicable to all relevant service settings) and improving diagnosis of dementia in hospitals

11.13 In order to sustain performance against achieved CQUIN goals year on year, commissioners may wish to include some of the previous year's CQUIN indicators within contract quality requirements and continue to monitor performance using the standard mechanism for Service Quality Reviews set out in Section E Clause 45. The CQUIN scheme set should be reserved for progressive improvements year on year.

Developing and agreeing the provider's CQUIN scheme

11.14 It is incumbent on commissioners to make 2.5% of contract value (or equivalent non-contract activity value) available for each provider's CQUIN scheme – and to co-operate to reach agreement on a single CQUIN scheme per provider. Where the provider has multiple NHS commissioners, this single agreed scheme should be set out in all provider contracts. For purposes of clarity and transparency, payment should be made on the basis of achievement against the whole scheme by all commissioners.

11.15 There are three exceptions to the one scheme per provider arrangement, where more than one scheme will be needed:

Services commissioned by SCGs

Local SCGs are responsible for agreeing a CQUIN scheme with each provider of specialised services in their area, related to the contract value associated with those services. SCGs should work with the main PCT commissioner in order to avoid duplication or conflict between CQUIN schemes.

Providers with sites in more than one region (eg. national independent or third sector providers)

In order to reflect local quality improvement priorities, one CQUIN scheme should be agreed for each provider site or for each provider contract, with a lead PCT per scheme. Multiple CQUIN schemes for a single provider should have regard to the specific circumstances of the provider and effective use of resources across the national provider's multiple sites or services.

Vertically integrated community services

Where a significant range of community services is commissioned from an acute or mental health provider using either separate contracts or an integrated provider contract, a separate CQUIN scheme for community services should be set out within that contract. However, consideration should be given to including common goals across the two service types.

11.16 In addition to the required exceptions outlined above, it may be appropriate in exceptional circumstances for local organisations to choose to agree a CQUIN scheme per contract, rather than per provider; for example where principal commissioners contract with a Provider primarily for services delivered by distinct community-based units, serving different populations (most likely to be in community or mental health), with no overlap in quality improvement priorities.

11.17 In all other circumstances, commissioners should work together in order to agree one CQUIN scheme per provider, even where coordinated or collaborative commissioning is not yet in place. CQUIN schemes are not intended to be comprehensive of all provider services. Therefore, small differences in the range or volume of services contracted by different commissioners cannot be used as an argument for separate CQUIN schemes; and any further local exceptions need to be approved by the provider's host SHA.

CQUIN scheme reporting and payment

11.18 Whilst a provider should have a single CQUIN scheme reflected in all its contracts for patient services, (exceptions listed in paragraph 11.15 above), the financial values, payment schedules and reporting schedules set out in the relevant schedule should relate only to those commissioners using this contract. In this way, reporting and payment arrangements should align with the provider's wider contractual arrangements to avoid confusion. Payment and reporting schedules should also reflect the general contractual arrangements.

11.19 Provider performance against the CQUIN scheme should be reviewed in line with the frequency of reviews agreed under Section E clause 46 of this contract. The commissioner and provider may choose to undertake this review alongside the Service Quality Review undertaken under Section E Clause 45 of this contract.

11.20 Payment arrangements must be agreed between commissioner and provider and set out in this schedule.

11.21 In most cases, it is recommended that 1/12 of 50% of the expected total value of the CQUIN scheme (based on estimated total outturn contract value as at month one) is paid to the provider each month for cash flow purposes, with final reconciliation against

achievement of goals and Actual Outturn Value at year-end. This means that the provider repays some of the CQUIN payment if the CQUIN goal is not achieved.

11.22 In the case of a very small provider, a care home or a zero-based AQP type contract, it may be appropriate and simpler to make a single CQUIN payment at year-end based on achievement of goals and the Actual Outturn Value of the contract, with no advance payments. This approach mirrors the recommended approach for non-contract activity.

11.23 For clarity and simplicity, providers should issue separate invoices for any balancing payments for the CQUIN scheme.

12. Information requirements

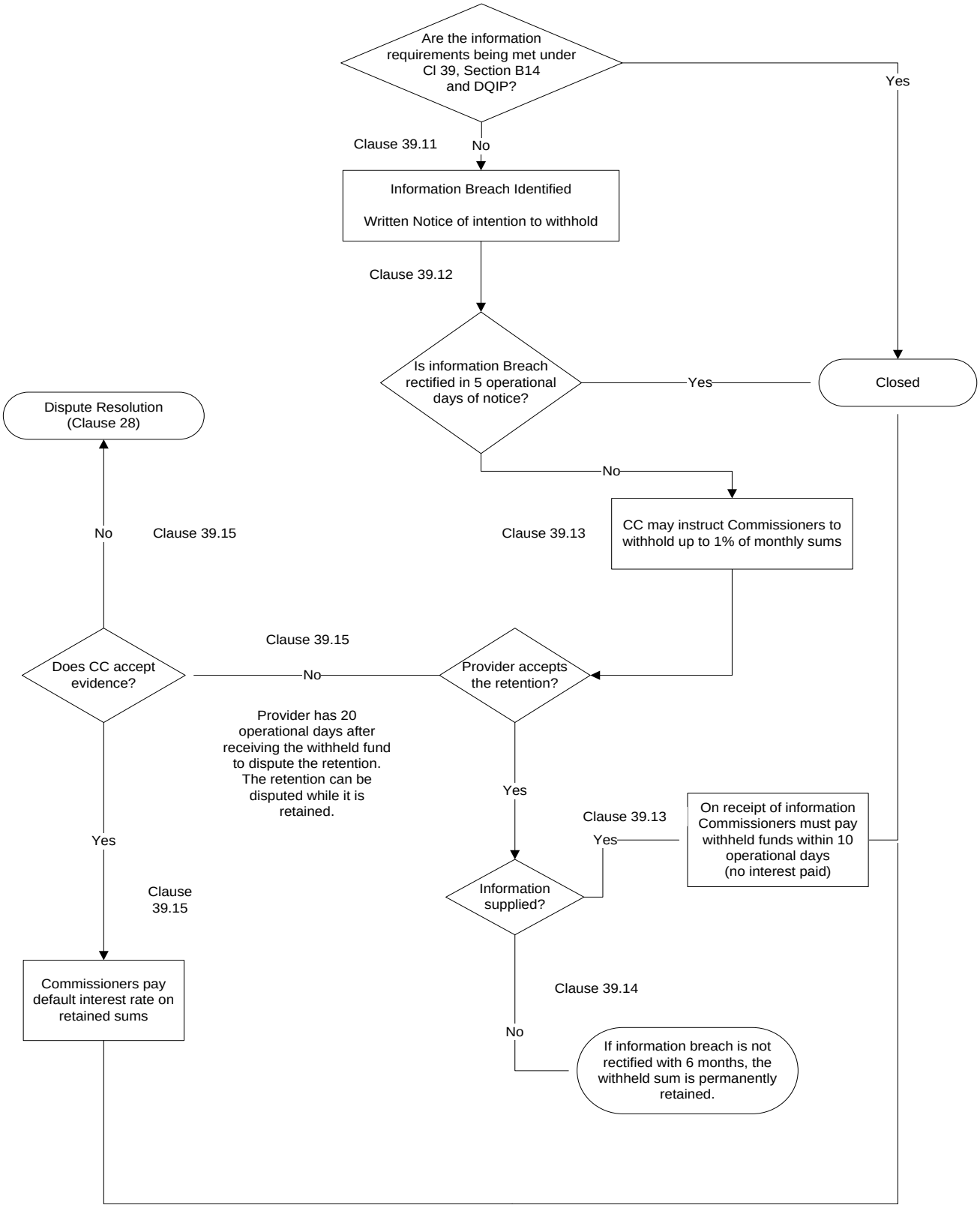
12.1 Good quality information is essential to enable providers and commissioners to monitor their performance against the contract. The following guiding principles should underpin the provision of information to support contract management:

- the provision of information should be used for the overall aim of high quality service user care.
- it should be for a clear 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.
- information provided should be of good quality

12.2 Section E Clause 39 sets out the contractual requirements regarding the provision of information and the financial withholdings that can be applied for failure to provide this information. It is expected that the parties will resolve information matters in day-to-day dealings, with the contract setting the boundaries and rules where the normal relationship has failed to resolve issues.

Figure One

Information Requirements (Section E Clause 39)



12.3 Section B Part14 outlines the reports required under the Contract, which is broken down into the following parts:

- **Part 14.1** sets out the national requirements which are reported centrally. This includes compliance with the reporting requirements of SUS and UNIFY2 and the delivery of any data or definition set out in the Information Centre Guidance, Review of Central Returns (ROCR) and any Information Standard Notice (ISN) relevant to the service being provided – www.isb.nhs.uk

- **Part 14.2** lists the national requirements, which are to be reported through local systems. Many of these relate to reports mandated within the contract eg the provision of a regular service quality performance report

- **Part 14.3** is where any agreed requirements to be reported locally should be inserted. The Commissioners needs to be clear why these reports are required and whether the information is occasional or routine and set the timeframe, content and method of delivery for these reports accordingly

- **Part 14.4** provides a pro forma table for the Data Quality Improvement Plan (see below)

The Data Quality Improvement Plan (DQIP)

12.4 The DQIP allows the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data both to support the commissioning and contract management processes.

12.5 The DQIP should not be used to waive or delay the financial withholding against nationally mandated information items. Where there are issues relating to the provision of nationally mandated data items, these should be addressed through the use of Section E Clause 39.

12.6 The DQIP can be used to address issues relating to the improvement in accuracy and completeness of data for contract requirements, including the development of outcome based quality measures. For example, the DQIP can support:

- a new provider system upgrade enabling implementation of national datasets
- any plans that commissioners of acute hospital services may wish to include to increase the percentage coverage of the NHS number during the Service User episode over and above the national requirements.
- the sharing of anonymised information with local Community Safety Partnerships to tackle violent assault
- implementation of mental health PbR

12.7 Commissioner and providers should also build on any DQIP established in 2011/12 to reflect the expectation outlined in the Operating Framework that commissioners and providers will improve and monitor data quality.

12.8 Using the DQIP means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under Section E Clause 39 (Information Requirements) only if the requirements of the DQIP are not achieved.

Information management

12.9 The following section outlines a number of key issues commissioners and providers need to consider that relate to the provision of information under the Contract:

- information governance
- system compliance
- reporting requirements
- information services

Information Governance (IG) – service user data and its protection

12.10 All providers and commissioners should manage service user identifiable data in accordance with the Law, Good Clinical Practice and Good Health and Social Care Practice as defined in Section E Schedule 1. The NHS IG controls are designed to ensure the accuracy and traceability of any information stored on systems and to protect the confidentiality of service yser information.

12.11 It is a requirement of all providers wishing to provide NHS funded services that they meet the requirements set out in the NHS Connecting for Health (CfH) Information Governance Toolkit (IGT) and, where there is a requirement to integrate their IM&T solution to NHS CfH Systems and Services outlined below [1] , the provider will need to complete an Information Governance Statement of Compliance (IGSoC).

12.12 The IGT applies to all and the requirement is set out in Section E Clause 60. All parties are required to have met a minimum level 2 performance against the relevant NHS IGT. There are many organisation types listed and if it is unclear which version of the toolkit to complete online help is available:

https://www.igt.connectingforhealth.nhs.uk/ContactUs.aspx?tk=408596026206142&cb=14%3a33%3a53&clnav=YES&lnv=5

12.13 The IGSoC is the first compliance step towards gaining access to NHS CfH systems and services and is the agreement between a provider, commissioner and NHS CfH that sets out the information governance policy, terms and conditions to enable integration to the centrally managed systems and services listed below. It is a range of security related requirements, which must be satisfied in order for an organisation to be able to provide assurances in respect of safeguarding the N3 network and any information assets that may be accessed**.** Included in this process is the IGT and the nomination of a Senior Information Risk Owner and Caldicott Guardian. These key roles are a requirement of the contract and outlined below is a brief description for both roles:

[1] NHS CfH Systems and Services such as Choose and Book, PDS, NHS Mail, N3

- **Senior Information Risk Owner (SIRO)** – The nominated person needs to be an executive or senior manager on the Board who is familiar with information risks and the organisational response to risks. The SIRO takes ownership of the organisation's information risk policy, and ensures, working through senior staff responsible for information assets (Information Asset Owners), that there are regular reviews of information risk across the organisation and that all reasonable steps are taken to manage and mitigate against all key risks

- **Caldicott Guardian** – the role of the Caldicott Guardian is advisory, providing a focal point for confidentiality/information sharing issues and the management of service user information at Board level.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114509

12.14 It is also suggested that the provider nominates an informatics lead to support the contract. Their role would be to implement Section B Part 14 of the contract (Reporting and Information Management) and be responsible for meeting the requirements and any new information requirements that emerge during the life of the Contract. It is the responsibility of all commissioners to ensure that appropriate IG assurance is obtained when contracting for the delivery of information services. Further information on the IGSoC and IGT can be found at

http://www.connectingforhealth.nhs.uk/systemsandservices/infogov

12.15 The commissioner and provider should ensure that any suppliers and sub-contractor with access to Service User information and to any NHS CfH systems or services as part of the Contract meet the required IG obligations.

System Compliance

NHS Number	The NHS number is the national unique service user identifier that supports the sharing of information and is used to help healthcare staff and service providers match the service user to their health records. It is a required field within data returns to commissioners and should be contained in all referrals. For further information on the NHS standard can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber

To help facilitate the use of the NHS number, NHS CfH provides centrally managed applications for the retrieval of the NHS number as follows:

Patient Demographic Service (PDS)	PDS is the national electronic database of demographic details for service users and is available via a PDS compliant patient administration system (PDS). Further information on PDS can be found at http://www.connectingforhealth.nhs.uk/resources/systserv/nhs-personal

Summary Care Record application (SCRa)	The SCRa is a web based portal by which service user information held on the Spine[2] can be accessed. As with other centrally managed applications, access is controlled. Further information on SCRa can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/scr
Demographic Batch Service (DBS)	DBS enables a user to submit a file containing service user demographics for multiple service users, for tracing against the PDS. The correct NHS Number and demographics for each service user will be returned where an exact match is found. DBS will also return a deceased status for service users and information where no match has been made. Further information on DBS can be found at the following http://nww.connectingforhealth.nhs.uk/demographics/dbs

Reporting Requirements

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

Organisation Data Services (ODS)	The provider must acquire a unique ODS code for their organisation and separate site codes, where relevant, to support all central reporting. This code is the provider's unique ID that allows publication of services and activity undertaken for the NHS. For further information on ODS http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods
N3	In order to use NHS IT services the provider must obtain an N3 connection, there are several methods of connecting to the network. Further information on this service and options available can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/n3
NHS Mail	NHS mail is the secure, web based email and directory designed for NHS staff, providing secure email services for the transmission of service user identifiable data. All providers will be required to register for NHS mail and will need to discuss this provision with their commissioner. For further information on this service http://www.connectingforhealth.nhs.uk/systemsandservices/nhsmail

To enable information flows and meet the requirements of ROCR and ISB, the provider may require access to a number of reporting systems. Detailed below are the main collection methods and links to key information websites for further explanation:

[2] The Spine is a national, central database where for example the summary patient records are stored.

Secondary Uses Service (SUS)	SUS is the single comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS such as Commissioning Data Sets (CDS). The provider must register with SUS to enable submission and to register, the provider should email enquiries@ic.nhs.uk or call the NHS Information Centre (NHS IC) contact centre on 0845 300 6016, to request a log on. Further information on the service is available on – http://www.ic.nhs.uk/services/secondary-uses-service-sus
UNIFY2	Unify2 is the system for sharing and reporting NHS health care activity and performance information. The provider will be required to register for access to Unify. For further information and access to Unify, please contact – unify@dh.gsi.gov.uk
NHS OMNIBUS Survey	Omnibus is an online tool managed by the NHS IC to help NHS and social care organisations submit data. The provider and commissioner where appropriate will need to register with the NHS IC to support data submissions. Further information on OMNIBUS is available at http://www.ic.nhs.uk
Strategic Executive Information System (STEIS)	STEIS is used by NHS organisations for the collection of Incidents Requiring Reporting Section C Part 7.3 and Situation Reports (SITREP). For further information and agreement of method, please contact the local commissioner.

Information Services

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

Information Standards Board (ISB)	The ISB is the board responsible for setting information standards for the NHS and adult social care in England. Information Standard Notices (ISNs) are notices issued to commissioners and providers by the ISB giving instructions on information standards to be met. For further information: www.isb.nhs.uk.
Information Standard Notices ISNs	Providers and commissioners are required under the contract to implement all ISNs relevant to the services being provided that are issued during the life of the contract. An information standard describes a common way of managing information, which supports national initiatives. There is a registration system which provides notification of ISNs by email, see http://www.isb.nhs.uk/yoursay/index_html

Review of Central Returns (ROCR)	The ROCR process supports the Department of Health and its Arms Length Bodies to implement the Government's policy of reducing the burden of data collections from the NHS. It ensures: • collections fit with national health policies in England • requests for the same information are not repeated • NHS organisations can complete these in as little time as possible. For further information :http://www.ic.nhs.uk/services/the-review-of-central-returns-rocr
NHS Data Model and Dictionary Service	A reference point for all information standards that support healthcare activities and data definitions. http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/cds/cds_type_de.asp?shownav=1
NHS Information Centre (NHS IC)	The NHS Information Centre is England's central, authoritative source of health and social care information. It manages the national data repository and routine data flows between the health and care system and the centre. It publishes national and official statistics, indicators and measures used for national accountability. It has a key role in information governance and data quality assurance in relation to nationally collected and published data. In 2012/13 the NHS IC will be producing more comprehensive, regular and consistent reports on the quality of data submitted nationally by NHS organisations. These reports can be used locally by both providers and commissioners to monitor local data quality and inform declarations and assessments of quality accounts. The NHS IC produces information and reports such as the Secondary Uses Service (SUS) data quality dashboards and Mental Health Minimum Data Sets (MHMDS) data quality reports, to identify issues with the quality of nationally submitted data. Further information on the NHS IC is available: http://www.ic.nhs.uk The NHS IC also provides a searchable information catalogue of current, proposed and past national data collections relating to health and social care. http://www.icapp.nhs.uk/infocat/search.aspx?reset=true

13. Contract management

Managing activity and referrals

Overview

13.1 The contractual requirements relating to the management of activity and referrals have undergone major revision for the 2012/13 contract. This has been as a result of:

- merging four contracts into one, each with a different form of activity management
- the Cooperation and Competition Panel's report on the implementation of patient choice of any willing (now 'qualified') provider and the subsequent Department of Health response

(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131087)

13.2 The requirements relating to activity management are in Section E of the 2012/13 contract, and form part of the core legal clauses. The requirements relating to financial adjustments for 18 weeks performance and reduction in Clostridium difficile have been moved to Section E Clauses 43 and 44 and Section B Parts 8.4 and 8.5 of the 2012/13 contract.

Co-operation and Competition Panel report into the implementation of patient choice

13.3 In July 2011 the Cooperation and Competition Panel reported on the implementation of patient choice of any willing (now 'qualified') provider in elective services. The Department of Health responded to the nine recommendations made. A number of these have implications for the NHS Standard Contract and the process of activity planning and are outlined below:

Recommendation 1: The Department agrees that commissioners should ensure that their practices are in line with the PRCC

Recommendation 2: the Department agrees that any decisions that would restrict patient choice of provider for elective services must be approved at the level of PCT Boards and involve the relevant subcommittee of the Board, where established, to ensure the engagement of emerging CCGs and that any such decisions should be taken transparently and published annually.

Recommendation 3: the Department considers that the activity schedules should not be used as a mechanism to constrain patient choice and cap activity. PCTs should ensure all patients are seen on the basis of clinical need which in itself means there is no justification for the use of minimum waits that do not take account of health care needs of individual patients. Where prior approval schemes are used they should be transparent, non-discriminatory and should not be used to restrict patient choice of provider.

Recommendation 8: the Department considers that the Activity Planning provisions in the Standard Acute contract do remain necessary but recognises that they could be misused. The development of the 2012/13 Standard Acute Contract will take into account the CCP's findings and seek to ensure that abuses are less possible

.

13.4 As a result of the response to the recommendations, a number of changes have been made to the Activity Planning and Management clauses, in particular:

- the Activity Plan is now an Indicative Activity Plan and cannot be used to limit the amount of activity undertaken by a provider
- Variances between actual activity and the Indicative Activity Plan may still be reviewed but an activity management plan can only be used to address breaches in the Activity Planning Assumptions and not breaches in the activity plan
- The Prior Approval clauses have been amended to clarify that prior approval schemes which restrict or try to restrict patient choice are void.

Responsibilities of commissioners and providers in relation to managing activity

13.5 The contract sets out the respective responsibilities of commissioners and providers in managing activity.

13.6 Commissioners are responsible for managing the external demand for services e.g. through GP and other referrals. They should also ensure that referrers adhere to any agreed referral and treatment protocols.

13.7 Providers must accept any clinically appropriate referrals for secondary care for any patient who chooses that provider under Patient Choice and in accordance with Patient Choice Guidance. For services where Patient Choice and Patient Choice Guidance does not apply, providers should accept referrals in accordance with the service specifications. Providers are responsible for managing activity in accordance with any Activity Planning Assumptions (see below).

13.8 Providers must work with the commissioner in understanding and managing referrals but are not responsible for overseeing any referral management processes except where they relate to Prior Approval Schemes (see Prior Approval Scheme below)

Processes for managing activity and referrals

Indicative Activity Plan (IAP)

13.9 Prior to the start of the contract year or, in the case of a new contract, during the negotiation period, the commissioner and provider must agree an IAP. This IAP is an indication of the activity that the parties to the contract estimate may be required during the contract year. It is **not** a guarantee of or a cap on actual activity that will be provided.

13.10 A non-mandated activity plan template for acute hospital services is available on the 2012/13 Standard Contracts webpage of the DH website. Commissioners and providers

will need to capture the required baseline for emergency activity to enable calculation of the tariff for emergency activity, as outlined in the 2012/13 Operating Framework http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Planningframework/index.htm

13.11 In constructing the indicative activity plan, the parties may wish to take account of any seasonal profile of activity and therefore review activity in this context.

13.12 IAPs can be agreed for activity provided within a fixed price (block) contract, and where appropriate commissioners and providers can mutually agree to an Indicative Activity Plan of zero, for example for AQP contracts.

13.13 Where the commissioner wishes to agree an IAP and the provider fails to agree an IAP with the commissioner, the IAP is set at zero for the relevant contract year.

13.14 The detailed IAP should include sufficient detail for both parties to understand what indicative activity is being proposed and any thresholds for reporting purposes that are required by the commissioner.

13.15 Where there are a number of commissioners, the overall IAP should be made up of all the co-ordinated commissioners' IAPs and an individual IAP for each commissioner so that the provider can identify indicative activity for each commissioner.

Activity Planning Assumptions (APA)

13.16 Activity Planning Assumptions set out planning assumptions relating to how the provider will manage their internal activity once a referral has been accepted. These assumptions may be used by the commissioner to develop the IAP. These replace the Commissioning Ambitions which were used in previous versions of the acute contract.

13.17 It is non-mandatory to have APA and they are likely to be more widely used for contracts covering acute hospital services. They should **not** be used in such a way as to restrict patient choice.

13.18 The APA may relate to specific areas of care (clinical thresholds) or across a number of specialities e.g. Consultant to Consultant referrals. APA must be based on best practice and be evidence based. They must be measurable. Examples include:

- first to follow up outpatient ratios
- consultant to consultant referrals

13.19 The commissioner will notify the provider of any APA prior to the service commencement date.

13.20 Each APA must indicate a threshold for reporting purposes. The threshold is not for numbers or volumes of patients to be treated, but the point at which the provider is expected to notify the commissioners of the breach without delay. This will allow the commissioner and provider to understand any unexpected changes to clinical workloads and may result in a variation to the APA being agreed.

13.21 APA should be detailed in Section B Part 4 and a model template is available on the 2012/13 standard contracts web page.

Monitoring of activity and activity management

13.22 The provider will be required to submit an activity report in the format and at the frequency agreed with the commissioner.

13.23 The commissioner and provider will use the activity report to monitor actual activity carried out by the provider against:

a. the IAP
b. any APA detailed within the contract

13.24 The parties will review any variances in activity or activity planning assumptions.

13.25 Where there has been a breach in the threshold for an APA, the commissioner will notify the provider without delay. A breach may happen outside of the normal reporting mechanism, and 'without delay' will be dependent on the frequency and timing of the Activity Report as detailed in the Information Schedule.

13.26 After reviewing the breach the commissioner may require the provider to agree an Activity Management Plan (AMP) as per Section E Clause 41.12.2. Once agreed the AMP must be appended to the contract at Section B Part 5 and should detail:

1. the APA threshold that has actually been breached for example new to follow up ratios, consultant to consultant referrals
2. any review findings that are relevant to the breach. (Section E Clause 46)
3. an analysis of the causes and factors that relate to the breach
4. specifically agreed actions and timescales for those actions to be met and completed
5. consequences of breaching the AMP and consequences of failing to implement the agreed AMP

13.27 If the Provider breaches an AMP or fails to implement the agreed AMP the consequences set out in the AMP will apply.

Prior Approval Schemes

13.28 Any prior approval schemes should be notified by the commissioner prior to the start of each contract year.

13.29 It is important to note that any prior approval scheme which restricts patient choice is void and for the purposes of the contract cannot be used to restrict payment for activity carried out by the provider.

Risk share agreements

13.30 The contract allows for risk share agreements to be entered into. These relate only to mental health services. Where a risk share agreement is agreed, it should be appended to the contract in Section D Part 5.

13.31 Risk share agreements must be in accordance with any relevant guidance, including PbR guidance.

Contract review process

13.32 The contract review process is set out in Section E Clause 46. The parties may agree a suitable interval between reviews, which should be at least every six months.

13.33 The frequency of reviews will depend on the size of the contract and the level of financial or clinical risk involved.

13.34 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.

13.35 Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the Quality and Information schedules.

13.36 Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.

13.37 The review process will be used to agree any amendments for each Contract Year.

Contract management process

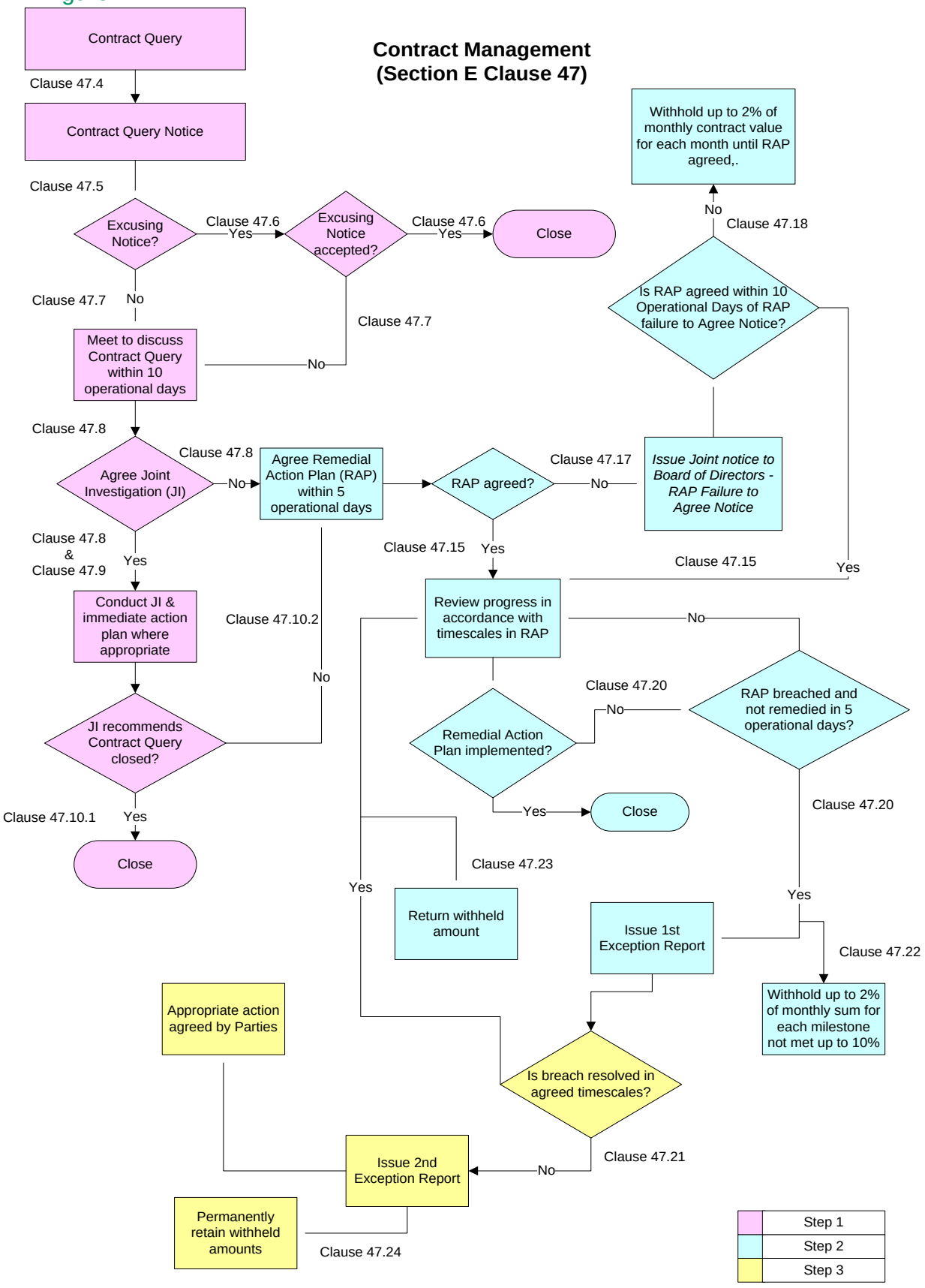
13.38 The contract management process is unchanged from the 2011/12 standard contracts. There are a number of stages to the contract management process. These can be summarised as follows:

- issue of contract query
- excusing notice (where relevant)
- meet to discuss the Contract Query
- implement a Remedial Action Plan and/ or Joint Investigation
- withhold funding in the event of failure to agree a Remedial Action Plan
- issue an Exception Report where there is a breach in the Remedial Action Plan which remains unremedied and withholding of funding

- issue a Second Exception Report to the Boards where there is a breach of timescales for remedy identified in the First Exception Report and permanently retain withheld funding

More detail is included in Figure 2.

Figure 2


Contract Management
(Section E Clause 47)
Contract Query
Clause 47.4
Contract Query Notice
Clause 47.5
Excusing Notice?
Clause 47.6
Yes
Excusing Notice accepted?
Clause 47.6
Yes
Close
Clause 47.7
No
Clause 47.7
Meet to discuss Contract Query within 10 operational days
No
Clause 47.8
Agree Joint Investigation (JI)
Clause 47.8
No
Agree Remedial Action Plan (RAP) within 5 operational days
RAP agreed?
Clause 47.17
No
Issue Joint notice to Board of Directors - RAP Failure to Agree Notice
Clause 47.8
&
Clause 47.9
Yes
Clause 47.15
Yes
Clause 47.15
Yes
Conduct JI & immediate action plan where appropriate
Clause 47.10.2
No
Review progress in accordance with timescales in RAP
No
JI recommends Contract Query closed?
Clause 47.20
No
Remedial Action Plan implemented?
RAP breached and not remedied in 5 operational days?
Clause 47.10.1
Yes
Yes
Close
Clause 47.20
Clause 47.23
Yes
Return withheld amount
Yes
Issue 1st Exception Report
Clause 47.22
Withhold up to 2% of monthly sum for each milestone not met up to 10%
Appropriate action agreed by Parties
Is breach resolved in agreed timescales?
Clause 47.21
No
Issue 2nd Exception Report
Permanently retain withheld amounts
Clause 47.24
Withhold up to 2% of monthly contract value for each month until RAP agreed,.
No
Clause 47.18
Is RAP agreed within 10 Operational Days of RAP failure to Agree Notice?
Step 1
Step 2
Step 3

14. Prices and payment

14.1 The arrangements for payment are set out in Section E Clause 7. This clause covers:

- the different types of pricing arrangements
- payment arrangements
- reconciliation
- other matters

14.2 In relation to prices, the contract specifies two different types of prices:

- National Tariff: this should be used for all services to which national tariff applies, in line with PbR guidance. There are two options within the national tariff: national tariff plus market forces factor, which the contract calls full tariff and, secondly, Variations to Tariff Prices. PbR guidance sets out the scenarios under which Variations to Tariff Prices can be used

- Non-tariff prices: these should be used for all services to which national tariff does not apply.

14.3 Payment arrangements will depend on whether the provider is a small provider. A small provider is defined as a provider with fifty or fewer full time equivalent employees (in total, not per contract) and whose expected annual contract value under the contract is £130,000 or less

14.4 For small providers who have a contract with an expected annual contract value (ie not a zero based contract) the commissioner will pay the provider quarterly in advance a quarter of the expected annual contract value.

14.5 For other providers where there is an expected annual contract value the commissioner will pay on a monthly basis one twelfth of the expected contract value.

14.6 Where there is no expected annual contract value, the provider should issue a monthly invoice based on the actual services provided.

14.7 Reconciliation will be required where payment is on the basis of a monthly/quarterly proportion of the expected annual contract value. It will not be required for 'block' contracts. Actual activity should be reconciled against the payments already made. For small providers and also for services where a non-tariff price applies, the commissioner sends the provider a reconciliation account, using the activity information provided by the provider, which should show the relevant prices against the activity completed.

14.8 Reconciliation for providers that are not small providers will generally be monthly. However, the 2012/13 PbR guidance suggests quarterly reconciliation may be an option for mental health PbR. The reference in Section E Clause 7.17 to PbR guidance allows for mental health PbR activity to be reconciled quarterly.

14.9 For services where national tariff applies, reconciliation should be completed according to the PbR process, allowing for validation of data.

14.10 The reconciliation process is outlined in Figures 3 and 4.

Figure 3

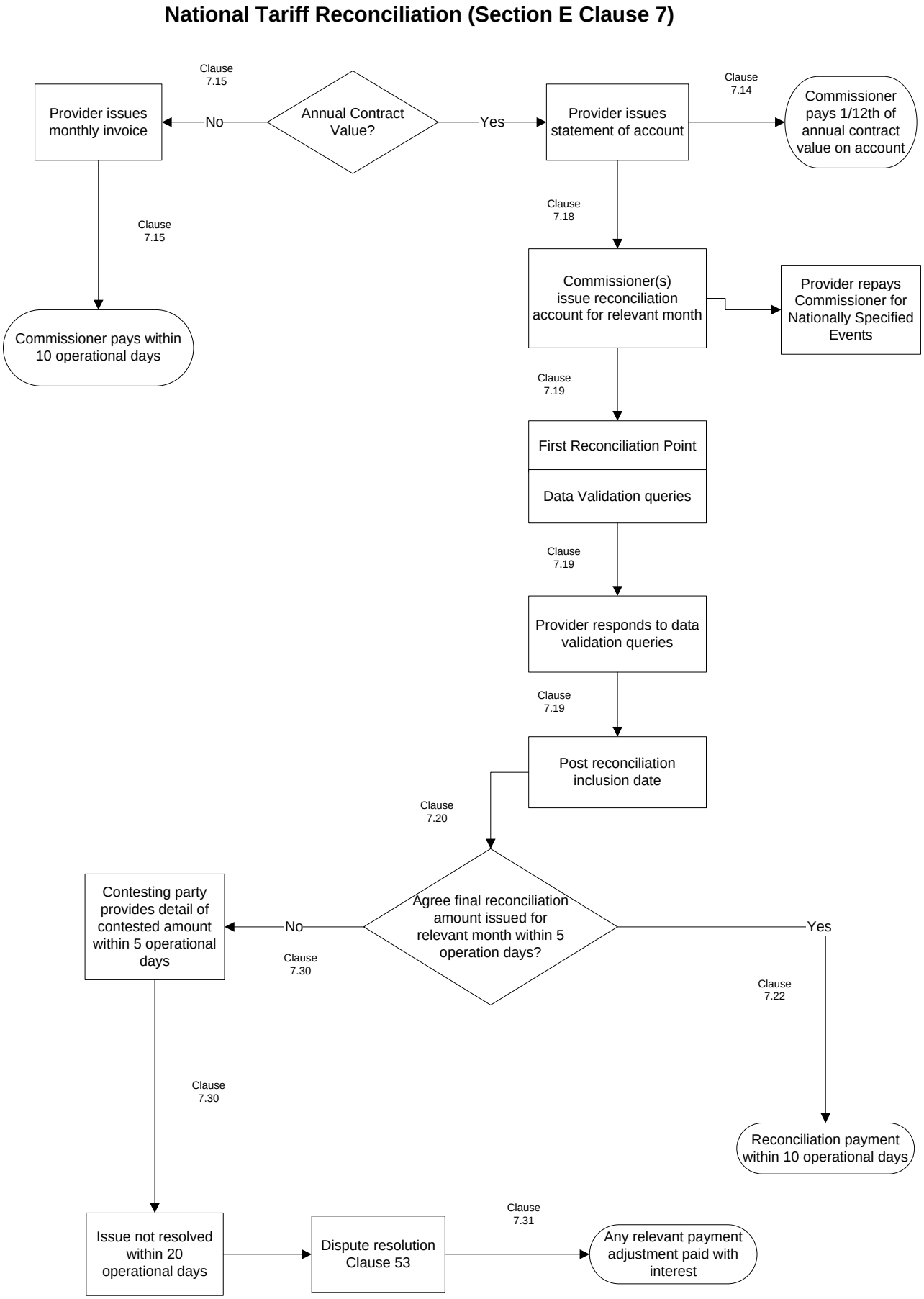
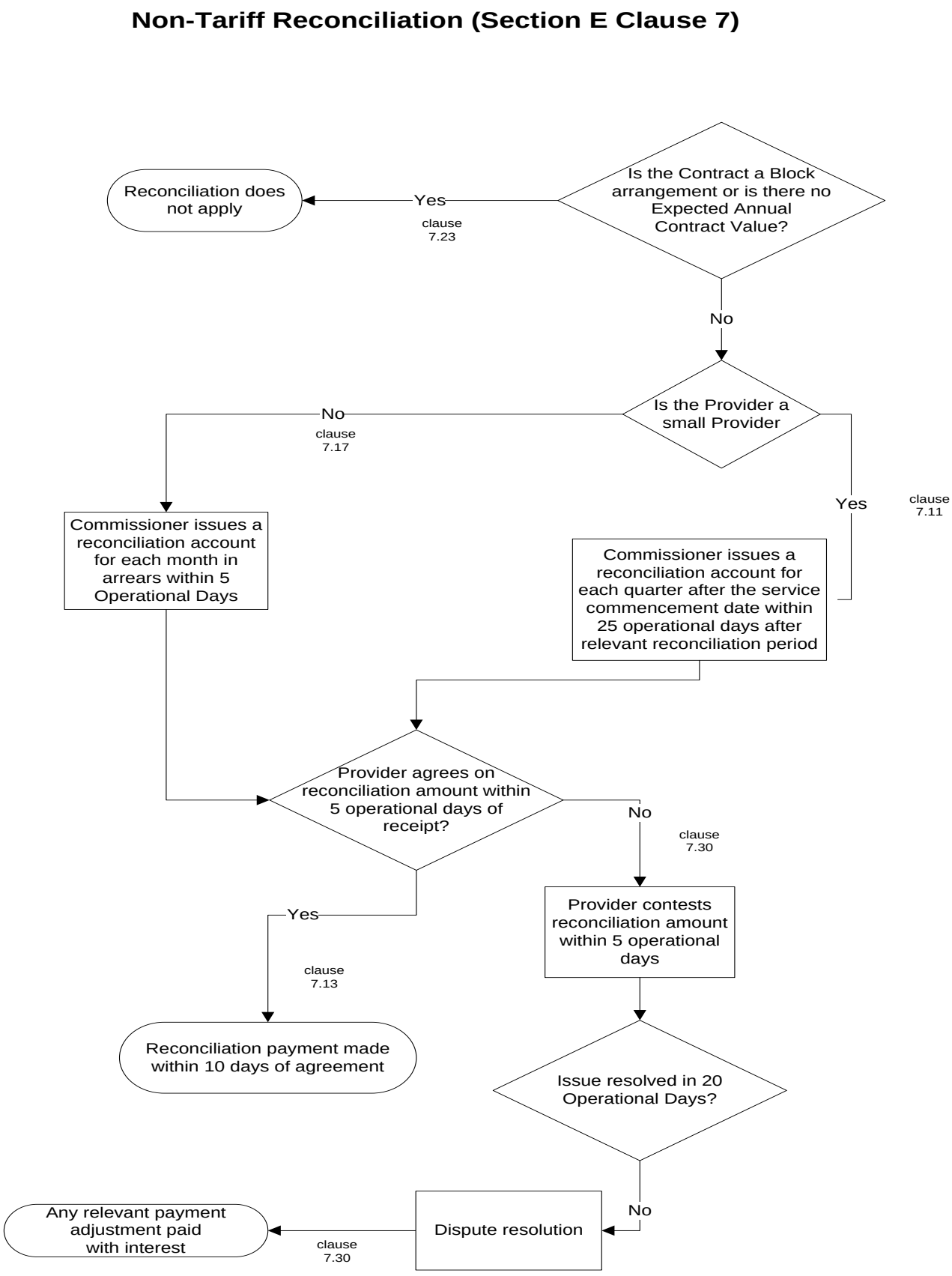

National Tariff Reconciliation (Section E Clause 7)
Clause 7.15
Provider issues monthly invoice
No
Annual Contract Value?
Yes
Provider issues statement of account
Clause 7.14
Commissioner pays 1/12th of annual contract value on account
Clause 7.15
Commissioner pays within 10 operational days
Clause 7.18
Commissioner(s) issue reconciliation account for relevant month
Provider repays Commissioner for Nationally Specified Events
Clause 7.19
First Reconciliation Point
Data Validation queries
Clause 7.19
Provider responds to data validation queries
Clause 7.19
Post reconciliation inclusion date
Clause 7.20
Agree final reconciliation amount issued for relevant month within 5 operation days?
No
Contesting party provides detail of contested amount within 5 operational days
Clause 7.30
Yes
Clause 7.22
Reconciliation payment within 10 operational days
Clause 7.30
Issue not resolved within 20 operational days
Dispute resolution Clause 53
Clause 7.31
Any relevant payment adjustment paid with interest

Figure 4


Non-Tariff Reconciliation (Section E Clause 7)
Is the Contract a Block arrangement or is there no Expected Annual Contract Value?
Yes
clause 7.23
Reconciliation does not apply
No
Is the Provider a small Provider
No
clause 7.17
Yes
clause 7.11
Commissioner issues a reconciliation account for each month in arrears within 5 Operational Days
Commissioner issues a reconciliation account for each quarter after the service commencement date within 25 operational days after relevant reconciliation period
Provider agrees on reconciliation amount within 5 operational days of receipt?
No
clause 7.30
Yes
clause 7.13
Reconciliation payment made within 10 days of agreement
Provider contests reconciliation amount within 5 operational days
Issue resolved in 20 Operational Days?
No
Dispute resolution
clause 7.30
Any relevant payment adjustment paid with interest

15. Contracts transition

15.1 Implementation of the Health and Social Care Bill will require PCTs to transfer approximately 75,000 clinical service contracts or agreements. Whilst recognising that the Bill remains subject to Parliamentary approval, PCT clusters need to start planning now to ensure that contracts will be safely and effectively transferred to new commissioning authorities by April 2013.

15.2 The Dear Colleague letter of 10th November 2011*: 'Planning for contract transfer' gateway reference 81618* http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_131035 sets out the process and described the tools available for the transition of contracts to the new commissioning bodies.

15.3 The process of transferring contracts should be underpinned by a set of core principles:

- continuity of clinical care must not be threatened during contract transition
- a consistent and objective approach is required
- there will be openness, transparency and visibility of progress
- management action should be proportionate to the risks identified
- it is the responsibility of the current contracting authorities to prepare contracts for transfer and ensure no 'net gain' or 'net loss' due to the transfer process
- it is the responsibility of new contracting authorities to establish the management controls and operational processes to receive contracting responsibilities and maintain continuity of service with any clinical, financial and legal risks addressed

15.4 PCT clusters will be expected to lead three phases of work to assure a smooth transfer of healthcare service contracts:

Stocktake – identify agreements held by existing contracting authorities, profile them, and perform a risk assessment on each one. The risk assessment will identify areas of improvement required before contracts are transferred to new authorities

Stabilise – address identified risks with targeted actions to safeguard transition

Shift – operationally and formally transfer contracts and contracting responsibilities to the new contracting bodies.

15.5 The Stabilise phase will use the risk assessment, produced during Stocktake, and address actions in the deficiency of documentation and management controls so that agreements can be transferred to the new contracting bodies.

15.6 The activities required within the stabilise phase will be:

- Provide notification to providers of the changes required in documentation to address risks identified through the Stocktake

- PCT Clusters, SCG Clusters and providers will determine which of these changes can be introduced: 1) immediately through normal contract variations, because no further negotiation or dialogue is required; 2) through 2012/13 contract agreements; or 3) partially addressed in the 2012/13 contract discussion and concluded in year during 2012/13 or in highly exceptional cases in the 2013/14 discussion (the latter to be by exception only).

15.7 SCG Clusters will be responsible, on behalf of PCTs, for the completion of the three phases of the transition of contracts for specialised services commissioned by SCG Clusters. This will be overseen by the Host PCT of the respective SCG Cluster with regard to formal sign off.

15.8 NHS London (who formally hold the national contracts for highly specialised services) will be responsible, through the National Specialised Commissioning Team (NSCT) for completing the transition exercise.

15.9 SCG Clusters are expected to have divested themselves of any non-specialised services contracts by March 2012.

15.10 All SCG Clusters are required to work closely with their PCT Clusters and providers to separate out specialised services activity (using the national information algorithm) for the agreed 'minimum take' list of services agreed by the Transitional Oversight Group for specialised services for March 2012.

15.11 Further guidance is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131039

Annex one: summary guide to completing the contract

A.1 This annex provides a summary of the key elements that should be completed in the period leading up to the commissioner and the provider signing the contract and a guide to some of the key clauses in the contract.

A.2 Appropriate legal advice should be sought in the event of any uncertainty as to the meaning of any specific terms in the contract.

The scope of the contract

A.3 There are two contract types published:

- A multilateral contract designed to be entered into by a group of commissioners, led by a co-ordinating commissioner and a single provider
- A bilateral contract designed to be entered into by a single commissioner and a single provider

A.4 It is a policy requirement that co-ordinating commissioning must be used when services from acute hospital service providers are procured or contracted.

A.5 For multilateral contracts, the co-ordinating commissioner's role is to provide the focal point of contact between the group of associate commissioners and the provider. The co-ordinating commissioner has a number of roles and responsibilities under the contract, which it exercises on behalf of all of the commissioners; this includes signing the contract on behalf of the other commissioners and acting as the lead commissioner for the provider/ commissioner relationship.

A.6 The relations between commissioners (including the co-ordinating commissioner) are governed by a separate Consortium Agreement, which must be in place before the Contract can be signed and before it can take effect.

A.7 Although the co-ordinating commissioner signs and has other key roles in relation to the contract, the other PCTs are bound by the agreement and should play an active part in the contract relationship through the co-ordinating commissioner. Commissioners that are in the commissioning consortium are legally bound by the contract terms.

A.8 The Contract contains provisions which are either:

- mandatory and non-variable
- mandatory, but for local agreement and definition
- non-mandatory, and for local agreement and definition

A.9 For ease these three levels have been colour coded:

- elements that are nationally mandated – there are no actions to take for any ‘Red’ items
- elements that are required for the contract to be legally executable but are for local negotiation / completion are identified as AMBER
- elements entirely for local negotiation and completion are identified as GREEN

A.10 Where a term in the contract is capitalised this means that the term is defined. Definitions are located in Schedule 1 of the Contract.

A Summary of the things to do locally

Section / Reference	Action
Cover Page	Insert the name of the Commissioner/ Co-ordinating Commissioner and the Provider
Section A - Particulars	
Agreement Date	Insert a date – this is the date that the contract is signed
BETWEEN (1)	Insert name and address of the Commissioner or the name of the Co-ordinating Commissioner
BETWEEN (1)	If Services are commissioned by an NCG/SCG then add the name and address of the NCG/SCG
BETWEEN (2)	Insert in name and address of Provider along with the Companies House/ Charity Commissioner Registration Number (where appropriate)
Longstop Date Clause 4.1, 4.3 and 5.1	Add dates for service commencement and Longstop Date. This is suggested at 3 months after the date the contract is actually signed.
Frequency of Review Meetings Clause 6.1	Add frequency agreed between the Commissioner and Provider for the meetings to jointly review the quality and performance Frequency could be monthly, quarterly or every six months. The frequency agreed is likely to be influenced by the financial value and/or the complexity of the services commissioned
Associates Clause 7.1	If the contract is a multilateral contract, list the names of the associates to the contract. If the contract is a bilateral contract nothing need be added here as the clause will be 'Not Used'
Notices Clause 8.1	Insert the addresses of the commissioner and provider and names and contact details of the person that will be the contact point for the commissioning organisation and the provider organisation
Final Page	The Co-ordinating Commissioner (or Commissioner if using Bilateral Contract) and Provider both sign this page
Final Page	Each Commissioner may also sign if desired
Section B - The Services	
Section B Part 1 Service Specification	Insert completed Service Specifications for each of the Services commissioned from the Provider See Chapter 9 for further guidance

Section / Reference	Action
Section B Part 2 Essential Services	The Commissioner may identify services that are key to the local health economy, which, if absent, would significantly affect the healthcare available to the local population. These Essential Services are the equivalent to the 'Mandated Goods and Services' applicable to a Foundation Trust. It is not necessary to add an FT's mandated goods and services to the Essential Services list
Section B Part 3 Indicative Activity Plan	Insert the Indicative Activity Plan. This plan is not an upper or lower cap or limitation on activity that a provider can undertake. A model template for acute services is available on the 2012/13 standard contracts web page. Where there is no activity agreed or identified, the Indicative Activity will be zero
Section B Part 4 Activity Planning Assumptions	Insert the Activity Planning Assumptions for the services. For multi lateral contracts, commissioners in the consortium should seek to have common Activity Planning Assumptions for all associates. Where this is not possible, the number of different Activity Planning Assumptions across the individual PCT associates should be kept to a minimum See Chapter 13 for further guidance .
Section B Part 5 Activity Management Plan	Any Activity Management Plan that is agreed in accordance with Section E Clause 41.12 should be inserted here
Section B Part 6.1 Non-Tariff Prices	Where the Services fall outside national tariff the commissioner and the provider will agree prices and will need to set them out in this section
Section B Part 6.1 Variations to Tariff Prices	Tariff is a fixed price, however in exceptional circumstances providers and commissioners can seek approval to operate an agreed variation of the regulated price, which is lower, but not higher, than the published tariff, provided that there is no adverse impact on quality, patient choice or competition. Where variations to tariff are agreed the detail should be recorded here
Section B Part 7 Expected Annual Contract Value	Insert the total Expected Annual Contract Value for each commissioner (this will form the basis of the 1/12th monthly payments or quarterly payments for small and large providers). The basis of the contract (block, cost and volume, cost per case) must be specified Where the Expected Annual Contract Value is zero, payment will be on the basis of actual activity undertaken
Section B Part 8.1 Quality Requirements	Quality requirements with amber sections are mandatory for any relevant services. The amber sections should therefore be completed where relevant for the Services. Where a Quality requirement cannot be applicable to the Services N/A should be inserted against it Commissioners and Providers can agree additional Quality Requirements for specific Services or covering all services provided under the contract

Section / Reference	Action
Section B Part 8.2 Nationally Specified Events	This lists the mandated performance requirements relating to the relevant services. The consequence set against these requirements identify the deduction that commissioners are to make following a breach This list cannot be amended or added to
Section B Part 9.1 National Incentive Scheme	There is no National Incentive Scheme. Accordingly this section should be left blank If in the future a National Incentive Scheme is published, it would be inserted here
Section B Part 9.2 Commissioning for Quality and Innovation (CQUIN)	Complete a template for each of the CQUIN indicators applicable for the providers. The mandated CQUIN indicators should be utilised where applicable to the Services. Guidance on the national CQUIN indicators is found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443 and on the 2012/13 Standard Contracts webpage Timescale details must be inserted in the relevant boxes- these are currently set at default timescales but may be amended
Section B Part 9.3 Locally Agreed Incentive Schemes	Where the Parties enter into a local incentive scheme over and above the CQUIN scheme the details of the local scheme should be inserted here
Section B Part 10 Eliminating Mixed Sex Accommodation (EMSA) Plan	Providers should agree their EMSA Plan where appropriate for the services environment and should insert the plan here. The relevant guidance is found in the professional letter PL/CNO/2010/3 issued by the Chief Nursing Office and the Deputy NHS CEO
Section B Part 11 Service Development and Improvement Plan (SDIP)	See Chapter 10 for further guidance
Section B Part 12 Service User, Carer and Staff Surveys	The details of the surveys should be entered here. This will include the frequency of the national and local surveys that are to be undertaken during the contract. Arising from the 2012/13 Operating Framework there is an expectation that local organisation should carry out more frequent surveys. Details should be agreed and set out here
Section B Part 13 Clinical Networks and Screening Programmes	Detail here any Clinical Networks and Screening Programmes that it is agreed that the Provider will participate in
Section 12 Part 14.2 National Requirements Reported Locally	This section lists the mandated information which is reported locally. The Parties should agree, as appropriate, and insert the frequency, format and method of delivery of information
Section B Part 14.3 Local Requirements Reported Locally	Providers and commissioners can agree additional information requirements to be reported locally. These should be inserted here
Section B Part 14.4 Data Quality Improvement Plan (DQIP)	The DQIP allows commissioners and providers to agree a local plan to improve the capture, quality and timeliness of data flows to support the commissioning and contract management processes The DQIP is non-mandatory and further guidance on its use can be found in Chapter 12.

Section / Reference	Action	
Section C - Service Matters		
Section C Part 1 Conditions Precedent	Additional matters that are required of the Provider and required locally to be in place BEFORE the service commences may be inserted at point 11 onwards. The requirements set out in points 1 to 10	
Section C Part 2 Documents to be Delivered by the Co-ordinating Commissioner/ Commissioner	Additional matters that are required to be delivered by the Commissioner to be provided BEFORE the Effective Date may be inserted at point 4 onwards. The remainder of the points are fixed.	
Section C Part 3 Transition Arrangements	The Transition Period is the time between signing the contract and services starting There may be certain events that need to take place in order that services commence smoothly which should be inserted here These are entirely for local agreement and are not a central requirement for contract execution	
Section C Part 4 Documents Relied On	If there are any documents, consents or certificates that are required, or that have been relied on by either party in deciding whether to enter the contract, these should be inserted here However, the documents should not include letters of intent that relate to commissioning assumptions, nor should it be used to endeavour to contradict or circumvent the mandated terms and conditions of this contract	
Section C Part 5 Material Subcontractors	There are a number of situations where the Provider may enter into a subcontracting arrangement with other organisations for an element of the care which they are commissioned to provide The Parties should agree which of the Provider's subcontractors are Material Subcontractors for the purposes of the contract and these should be set out here together with details of the Subcontract	
Section C Part 7.1 Transfer of and Discharge from Care Protocols	Any local agreement relating to the Service Users' transfer of and discharge from various care settings should be set out here. There is no central format for this. A single protocol will not necessarily satisfy the local demands of different commissioners but it is also recognised that the Providers are unlikely to be able to accommodate different protocols for all referrers Where consortium members want/need different transfer and discharge protocols the consortium should meet to 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 to broadly satisfy local requirements without over-burdening the Provider's ability to deliver	
Section C Part 7.2 Safeguarding Policies	Insert the adopted Safeguarding Policies. Any revision to the adopted Safeguarding Policies should be inserted during the Contract	

Section / Reference	Action	
Section C Part 7.3 Incidents Requiring Reporting Procedure	The Incidents Requiring Reporting Procedure should be inserted here	
Section C Part 8.1 Commissioner Intellectual Property	Any IPR owned or licensed by any Commissioner to be used by the Provider in the delivery of the Services should be agreed and listed here	
Section C Part 8.2 Provider Intellectual Property	Any IPR owned or licensed by the Provider and that is to be used in the delivery of the Services should be agreed and listed here	
Section C Part 9 Consortium Agreement	For multilateral contracts only commissioners must insert the signed PCT consortium agreement or SCG Establishment Agreement. This section will be blank where the agreement is a bilateral contract and identified as 'Not Used' Where a local authority is an associate to the contract the consortium agreement between the PCTs and the local authority becomes a legally binding contract which would be subject to determination in a court of law	
Section C Part 10 Local Commissioning Plans	Each commissioner who is a party to the contract will insert their Local Commissioning Plans here. This could be a link to the relevant document on the Commissioner's web site	
Section C Part 11 Exit Arrangement	Where the parties agree that there are costs associated with any of the services that will become payable by one of the parties on the expiry or termination of the agreement these should be identified and set out in this section prior to signing the contract. Where there are no exit payments to be made by either party this section should be marked 'None'	
Section C Part 12 Social Care Provisions	Where a service has been jointly commissioned by a local authority any specific local authority requirements associated with that Service should be inserted here.	
Section D – Recorded Variations, Disputes and Change of Control		
Section D Part 1 Recorded Variations	Any variation to the contract made under Section E Clause 52 (Variations) should be inserted here	
Section D Part 2 Notices to Aggregate/Disaggregate Payments	Where the commissioners agree to aggregate payments to the provider into one payment from the coordinating commissioner insert the notice to the provider here, or where payments to the provider are to be made by each associate to the contract insert the notice to the provider here	
Section D Part 3.1 Recorded Dispute Resolutions	The outcome of any disputes process should be recorded and the agreed note of the outcome should be inserted in this section	
Section D Part 3.2 Details of Mediator and Independent Binding Pendulum Adjudicator	This links to Section E Clause 53 - Disputes Resolution. Insert the details of the organisation that will act as the external mediator and adjudicator	
Section D Part 3.3 Procedure for Disputes Between Divisions of the Same NHS Body	Where the commissioner and the provider are departments within the same organisation the process for resolving any dispute between the two parts of the organisation should be inserted here	
Section E – Core Legal clauses and Definitions		
Clauses 1 - 79 inclusive and Definitions	No changes, amendments, variations or adjustment to any part of this Section is permitted other than in accordance with Section E Clause 52.2.2 – (Variations)	

Annex two: contract clause translation tables

NHS Standard Contract for Acute Services – Conversion Table

Particulars

Section in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
1	Agreement	A/1
2	Effective Date	A/2
3	Duration	A/3
4	Service Commencement	A/4
5	Longstop Date	A/5

Clauses 1-60 and Schedule 1

Clause in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract[3]
1	Definitions and Interpretations	1
2	Transition Period	2, 3 and 4
3	Commissioner and Representatives	48
4	Services	
	Service Provision	5
	Withholding and/or Discontinuation of Service	21
	Essential Services Continuity	16
	Business Continuity	49
	Care Planning	15
	Patient Involvement	8 & 9
	Other Services	12
	Transfers Pursuant to Local Commissioning Plans	31
	Unmet Needs	11
	HCAI Reduction Plan	33
	Ambulance Services Handover Plan	17.2
	Venous Thromboembolism	32
	Eliminating Mixed Sex Accommodation	30
	Service Development Improvement Plan	29
	Waiting Times	42

[3] Except as otherwise expressly indicated references in this column are to clause numbers in Section E.

	Patient Choice	10
	Other Clinical Arrangements	7
4A	Safeguarding Children and Adults in Vulnerable Circumstances	24
5	Services Environment and Equipment	22
6	Co-operation	18
7	Prices and Payment	7
8	Review	46
9	Consent	26
10	Complaints	27
11	Staff	23
12	Clinical and Other Networks and Screening Programmes	35
13	Not used	-
14	Death of a Patient	28
15	Incidents Requiring Reporting	25
16	Quality, Patient Safety and Screening Programmes	6
17	Procedures and Protocols	34
18	Transfer of and Discharge from Care Obligations	17 and Section C, Part 6A
19	Governance, Transaction Records and Audit	54
20	Managing Activity and Referrals	41
21	Patient Health Records	13
22	Confidential Information of the Parties	59
23	Intellectual Property	62
24	NHS Branding, Marketing and Promotion	61
25	Not used	-
26	Liability and Indemnity	50
27	Data Protection, Freedom of Information and Transparency	60
28	Dispute Resolution	53
29	Information Requirements	39
30	Not used	-
31	Service Standards	40
32	Contract Management	47
33	Service Quality Review	45
34	Suspension	55
35	Termination	56
36	Consequences of Expiry or Termination	57
37	Prohibited Acts	65
38	Variations	52
39	Warranties	64
40	Notices	75
41	Force Majeure	67
42	Emergency Preparedness and Resilience including Major Incidents	36
43	NHS Counter-Fraud and Security Management	37
44	Third Party Rights	68
45	Waiver	71

46	Entire Agreement	69
47	Severability	70
48	Assignment and Sub-contracting	51
49	Change in Control	63
50	Exclusion of Partnership	73
51	Non-Solicitation	74
52	Provisions Surviving Termination	58
53	Conflicts of Interest	66
54	Equity of Access, Equality and No Discrimination	19
	Pastoral, Spiritual and Cultural Care	20
55	Non-Contract Activity	7
56	Compliance with the Law	76
57	Counterparts	78
58	Remedies	72
59	Costs and Expenses	77
60	Governing Law and Jurisdiction	79
Schedule 1	Definitions and Interpretations	Schedule 1 Definitions and Interpretation.

Schedules 2-20

Schedule/Part in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
2	The Services	
2/1	Service Specifications	B/1
2/2	Transfer of and Discharge from Care Protocols	C/7.1
2/3	Major Incidents	C/7.5
2/4	Essential Services	B/2
2/5A	Non-Tariff Prices	B/6.1
2/5B	Reduced Tariff Prices	B/6.2
2/6	Frequency of Review Meetings	A/clause 6
3	Managing Activity and Referrals, Care and Resource Utilisation Techniques and Retention of Payment Scheme	
	General	-
	Contents and Thresholds	-
	Care and Resource Utilisation	-
	Prior Approval	41
	Utilisation Management	-
	Monitoring and Reporting of Activity	41
	Activity management following activity variations	41
	Financial adjustment for variations in activity	41
	Capacity review	-
	Delivery of the 18 weeks referral to	43

	treatment standard	
	Financial adjustments for performance in reducing Clostridium difficile	44
	Dispute resolutions	53
3/1 Annex 1A	Activity Plans	B/3
3/1 Annex 1B	Commissioning Ambitions based on Activity Plan	B/4
3/1 Annex 2	Capacity Review Criteria	-
3/1 Annex 3	Expected Annual Contract Values	B/7
3/2	Patient Booking and Patient Choice	E/clause 10
3/3	Not used	
3/4	Quality Requirements, Nationally Specified Events and Never Events	
3/4A	Quality Requirements	B/8.1
3/4B	Nationally Specified Events	B/8.2
3/4C	Never Events	B/8.3
3/5	Patient, Carer and Staff Surveys	B/12
3/6	Eliminating Mixed Sex Accommodation Plan	B/10
4	Transition	
4/1	Conditions Precedent	C/1
4/2	Documents to be delivered by the Co-ordinating Commissioner	C/2
4/3	Transition Arrangements	C/3
5	Information Requirements	
5/1	National Requirements Reported Centrally	B/14.1
5/2	National Requirements Reported Locally	B/14.2
5/3	Local Requirements Reported Locally	B/14.3
5/4	Data Quality Improvement Plan	B/14.4
6	Variations	
6/1	Variation Procedure	E/clause 52
6/2	Recorded Variations and Dispute Resolution	D/1
7	Service Development and Improvement Plan	B/11
8	Exit Arrangements and Agreements Relating to Termination Costs	C/11
9	Dispute Resolution	
9/1	Details of Mediator and Independent Binding Pendulum Adjudicator	D/3.2
9/2	Procedure for Disputes between divisions of the same NHS Body	D/3.3
10	Provider's Material Sub-contractors	
10/1	Definition of 'Material Sub-contract'	E/ Schedule 1

10/2	Material Sub-contractors	C/5.2
11	Consortium Agreements, Local Commissioning Plans, Notices to Aggregate/Disaggregate payments, Safeguarding Policy, Associates	
11/1	Consortium Agreement	C/9
11/2	Local Commissioning Plans	C/10
11/3	Notices to Aggregate/Disaggregate payments	D/2
11/4	Safeguarding Policy	C/7.2
11/5	Associates	A/clause 7
12	Incidents Requiring Reporting Procedure	C/7.3
13	NHS Counter-fraud and Security Management	
13/1	NHS Counter-fraud and Security Management for non-NHS Providers	E/clause 37
13/2	NHS Counter-fraud and Security Management for NHS Providers	E/clause 37
14	Documents Relied On	C/4
15	Change in Control Notification Pro-forma	D/4
16	Intellectual Property	
16/1	Provider IPR	C/8.2
16/2	Commissioner IPR	C/8.1
17	Notices	A/clause 8
18	Incentive Schemes	
18/1	Nationally Mandated Incentive Schemes	B/9.1
18/2	Commissioning for Quality and Innovation (CQUIN)	B/9.2
18/3	Locally Agreed Incentive Schemes	B/9.3
19	Location of Provider's Premises	B/1
20	Clinical Networks and Screening Programmes	B/13

NHS Standard Contract for Mental Health and Learning Disability Services – Conversion Table

The Particulars

Section in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
1	Agreement	A/1
2	Effective Date	A/2
3	Duration	A/3
4	Service Commencement	A/4
5	Longstop Date	A/5

Clauses 1-60 and Schedule 1

Clause in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract[4]
1	Definitions and Interpretations	1
2	Transition Period	2, 3 and 4
3	Commissioner and Representatives	48
4	Services	
	Service Provision	5
	Withholding and/or Discontinuation of Services	21
	Essential Services Continuity	16
	Business Continuity	49
	Care Planning	15
	Service User Involvement	8 and 9
	Places of Safety	14
	Provider Partnership Arrangements	38.1
	Other Services	12
	Transfers Pursuant to Local Commissioning Plans	31
	Unmet Needs	11
	Service Users under the Age of 18	-
	Social Care Provisions	5 and section C/12
	HCAI Reduction Plan	33
	Eliminating Mixed Sex Accommodation	30
	Service Development and Improvement Plan	29
	Waiting Times	42
	Patient Choice	10
4A	Safeguarding Children and Adults in Vulnerable Circumstances	24
5	Services Environment and Equipment	22
6	Co-operation	18

[4] Except as otherwise expressly indicated references in this column are to clause numbers in Section E.

7	Prices and Payment	7
8	Review	46
9	Consent	26
10	Complaints	27
11	Staff	23
12	Clinical and Other Networks and Screening Programmes	35
13	Emergency and Crisis Care	5.3 & C/7.4
14	Death of a Service User	28
15	Incidents Requiring Reporting	25
16	Quality, Patient Safety and Quality Improvements	6
17	Procedures and Protocols	34
18	Transfer of and Discharge from Care Obligations	17 and Section C, Part 6B
19	Governance, Transaction Records and Audit	54
20	Managing Activity and Referrals	41
21	Service User Health Records	13
22	Confidential Information of the Parties	59
23	Intellectual Property	62
24	NHS Branding, Marketing and Promotion	61
25	Not used	-
26	Liability and Indemnity	50
27	Data Protection, Freedom of Information and Transparency	60
28	Dispute Resolution	53
29	Information Requirements	39
30	Not used	-
31	Service Standards	40
32	Contract Management	47
33	Service Quality Review	45
34	Suspension	55
35	Termination	56
36	Consequences of Termination	57
37	Prohibited Acts	65
38	Variations	52
39	Warranties	64
40	Notices	75
41	Force Majeure	67
42	Emergency Preparedness and Resilience including Major Incidents	36
43	NHS Counter-Fraud and Security Management	37
44	Third Party Rights	68
45	Waiver	71
46	Entire Agreement	69
47	Severability	70
48	Assignment, Gatekeeping and Sub-contracting	51
49	Change in Control	63
50	Exclusion of Partnership	73

51	Non-Solicitation	74
52	Provisions Surviving Termination	58
53	Conflicts of Interest	66
54	Equity of Access, Equality and No Discrimination	19
	Pastoral, Spiritual and Cultural Care	20
55	Non-Contract Activity	7
56	Compliance with the Law	76
57	Counterparts	78
58	Remedies	72
59	Costs and Expenses	77
60	Governing Law and Jurisdiction	79
Schedule 1	Definitions and Interpretations	Schedule 1

Schedules 2-20

Schedule/Part in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
2	The Services	
2/1	Service Specifications	B/1
2/2	Essential Services	B/2
2/3	Activity Plans	B/3
2/4	Expected Annual Contract Values	B/7
2/5	Frequency of Review Meetings	A/clause 6
2/6	Eliminating Mixed Sex Accommodation Plan	B/10
3	Quality Requirements and Nationally Specified Events	
3.1	Quality Requirements	B/8.1
3.2	Nationally Specified Events	B/8.2
3.3	Never Events	B/8.3
4	Incentive Schemes	
4/1	Nationally Mandated Incentive Schemes	B/9.1
4/2	Commissioning for Quality and Innovation (CQUIN)	B/9.2
4/3	Locally Agreed Incentive Schemes	B/9.3
5	Information Requirements	
5/1	National Requirements Reported Centrally	B/14.1
5/2	National Requirements Reported Locally	B/14.2
5/3	Local Requirements Reported Locally	B/14.3
5/4	Data Quality Improvement Plan	B/14.4
6	Variations	

6/1	Variation Procedure	E/clause 52
6/2	Recorded Variations and Dispute Resolutions	D/1
7	Managing Activity and Referrals	
	General	-
	Development of Activity Plan	-
	Monitoring and Reporting of Activity	E/41
	Activity management following activity variations	E/41
	Prior Approval Scheme	E/41
	Risk Share Agreement	E/41.25
	Cost and Volume	-
	Delivery of the 18 weeks Referral-to-Treatment standard for Consultant-led Services	43
	Dispute Resolution	53
7/2	Emergency and Crisis Care Procedure	C/7.4
7/3	Transfer of and Discharge from Care Protocols	C/7.1
8	Transition	
8/1	Conditions Precedent	C/1
8/2	Documents to be delivered by the Co-ordinating Commissioner	C/2
8/3	Transition Arrangements	C/3
8/4	Exit Arrangements and Agreements Relating to Termination Costs	C/11
9	Dispute Resolution Procedure	
9/1	Details of Mediator and Independent Binding Pendulum Adjudicator	D/3.2
9/2	Procedure for Disputes between divisions of the same NHS Body	D/3.3
10	Provider's Material Sub-Contractors	
10/1	Definition of 'Material Sub-contract'	E/Schedule 1
10/2	Material Sub-contractors	C/5.2
11	Surveys, Local Commissioning Plans, SDIP, Partnership Arrangements, Safeguarding Policy, Consortium Agreement, Associates and Notices to Aggregate/Disaggregate Payments	
11/1	Service User, Carer and Staff Surveys	B/12
11/2	Local Commissioning Plans	C/10
11/3	Service Development and Improvement Plan	B/11
11/4	NHS/Local Authority Partnering	E/clause 38
11/5	Safeguarding Policy	C/7.2
11/6	Consortium Agreement	C/9
11/7	Associates	A/clause 7
11/8	Notices to aggregate/disaggregate	D/2

	payments	
12	Incidents Requiring Reporting Procedure	C/7.3
13	NHS Counter-fraud and Security Management	
13/1	NHS Counter-fraud and Security Management for non-NHS Providers	E/clause 37
13/2	NHS Counter-fraud and Security Management for NHS Providers	E/clause 37
14	Documents Relied On	C/4
15	Change in Control Notification Pro-forma	D/4
16	Intellectual Property	
16/1	Provider IPR	C/8.1
16/2	Commissioner IPR	C/8.2
17	Notices	A/clause 8
18	Social Care Provisions	C/12
19	Not used	-
20	Clinical Networks and Screening Programmes	B/13

NHS Standard Contract for Community Services – Conversion Table

The Particulars (Module A)

Section in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
1	Agreement	A/1
2	Effective Date	A/2
3	Duration	A/3
4	Service Commencement	A/4
5	Longstop Date	A/5
6	Conditions Precedent	E/clause 2 and C/1
7	Documents to be delivered by the Co-ordinating Commissioner	E/clause 3 and C/2
8	Transition Arrangements	E/clause 4 and C/3
9	Exit Arrangements and Agreements relating to Termination Costs	C/11
10	Notices	A/clause 8

The Services (Module B)

Section/Part in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
1	Services	
1/1	Specification	B/1
1/2	Service Development and Improvement Plan	B/11
1/3	Service User, Carer and Staff Surveys	B/12
1/4	Transfer of and Discharge from Care Protocols	C/7.1
2	Activity, Prices and Annual Contract Value	
2/1	Activity Plan	B/3
2/2A	Non-Tariff Prices	B/6.1
2/2B	Reduced Tariff Prices	B/6.2
2/2C	Annual Contract Value by Commissioner	B/7
3	Quality Requirements, Nationally Specified Events and Never Events	
3/1	Quality Requirements	B/8.1
3/2	Nationally Specified Events	B/8.2
3/3	Never Events	B/8.3
4	Incentive Schemes	
4/1	Nationally Mandated Incentive Schemes	B/9.1

4/2	Commissioning for Quality and Innovation	B/9.2
4/3	Locally Agreed Incentive Schemes	B/9.3
5	Information Requirements	
5/1	National Requirements Reported Centrally	B/14.1
5/2	National Requirements Reported Locally	B/14.2
5/3	Local Requirements Reported Locally	B/14.3
5/4	Data Quality Improvement Plan	B/14.4

Clauses 1 - 60 and Schedule 1 (Module C)

Clause in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract[5]
1	Definitions and Interpretation	1
2	Transition Period	4
3	Commissioner and Representatives	48
4	Services	
	Service Provision	5
	Withholding and/or Discontinuation of Service	21
	Essential Services Continuity	16
	Business Continuity	49
	Care Planning	15
	Patient Involvement	8 and 9
	Partnership Agreements	38
	Other Services	12
	Transfers Pursuant to Local Commissioning Plans	31
	Unmet Needs	11
	HCAI Reduction Plan	33
	Eliminating Mixed Sex Accommodation	30
	Service Development and Improvement Plan	29
	Waiting Times	42
	Patient Choice	10
4A	Safeguarding Children and Adults in Vulnerable Circumstances	24
5	Services Environment and Equipment	22
6	Co-operation	18
7	Prices and Payment	7
8	Review	46
9	Consent	26
10	Complaints	27
11	Staff	23
12	Clinical Networks and Other Screening Programmes	35

[5] Except as otherwise expressly indicated references in this column are to clause numbers in Section E.

13	Not used	-
14	Death of a Service User	28
15	Incidents Requiring Reporting	25
16	Quality, Service User Safety and Quality Improvements	6
17	Procedures and Protocols	34
18	Transfer of and Discharge from Care Obligations	17 and Section C, Part 6C
19	Governance, Transaction Records and Audit	54
20	Managing Activity and Referrals	41
21	Service User Health Records	13
22	Confidential Information of the Parties	59
23	Intellectual Property	62
24	NHS Branding, Marketing and Promotion	61
25	Not used	-
26	Liability and Indemnity	50
27	Data Protection, Freedom of Information and Transparency	60
28	Dispute Resolution	53
29	Information Requirements	39
30	Not used	-
31	Service Standards	40
32	Contract Management	47
33	Service Quality Review	45
34	Suspension	55
35	Termination	56
36	Consequences of Expiry or Termination	57
37	Prohibited Acts	65
38	Variations	52
39	Warranties	64
40	Notices	75
41	Force Majeure	67
42	Emergency Preparedness and Resilience including Major Incidents	36
43	NHS Counter-Fraud and Security Management	37
44	Third Party Rights	68
45	Waiver	71
46	Entire Agreement	69
47	Severability	70
48	Assignment and Sub-contracting	51
49	Change in Control	63
50	Exclusion of Partnership	73
51	Non-Solicitation	74
52	Provisions Surviving Termination	58
53	Conflicts of Interest	66
54	Equity of Access, Equality and No Discrimination	19
	Pastoral, Spiritual and Cultural Care	20
55	Non-Contract Activity	7
56	Compliance with the Law	76

57	Counterparts	78
58	Remedies	72
59	Costs and Expenses	77
60	Governing Law and Jurisdiction	79
Schedule 1	Definitions and Interpretations	Schedule 1

Schedule 2 to 17 (Module D)

Schedule/Part in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
2	Essential Services	B/2
3	Managing Activity and Referrals, Care and Resource Utilisation Techniques	
	General	-
	Care and Resource Utilisation	
	Prior Approval Scheme	41
	Utilisation Management	-
	Monitoring and Reporting of Activity	41
	Activity management following changes in activity	41
	Financial Adjustment for Variations in Activity	41
	Dispute Resolution	53
4	Variations	
4/1	Variation Procedure	E/clause 52
4/2	Recorded Variations and Dispute Resolution	D/1 and D/3
5	Dispute Resolution	
5/1	Details of Mediator and Independent Binding Pendulum Adjudicator	D/3.2
5/2	Procedure for Disputes Between Divisions of the Same NHS body	D/3.3
6	Material Sub-contractors	C/5
7	Consortium Agreement	C/9
8	Local Commissioning Plans	C/10
9	NHS/ Local Authority Partnering	
9/1	Provider Partnership Arrangements	E/clause 38
9/2	Commissioner Partnership Arrangements	E/clause 38
10	Safeguarding Policy	C/7.2

11	Incidents Requiring Reporting Procedure	C/7.3
12	NHS Counter-fraud and Security Management	
12/1	NHS Counter-fraud and Security Management for non-NHS Providers	E/clause 37
12/2	NHS Counter-fraud and Security Management for NHS Providers	E/clause 37
13	Documents Relied On	C/4
14	Intellectual Property	
14/1	Provider IPR	C/8.2
14/2	Commissioner IPR	C/8.1
15	Change in Control Notification	D/4
16	Frequency of Review Meetings	A/clause 6
17	Eliminating Mixed Sex Accommodation Plan	B/10

Acute Services Requirements (Module E)

Paragraph	Heading	Position in 2012/13 NHS Standard Contract
1	General	-
2	Not used	-
3	18 Week Referral to Treatment Standard	E/clause 43
4	Capacity Review in respect of the 18 Week Referral to Treatment Standard	E/clause 43
5	Patient Booking and Patient choice	E/clause 10
6	Financial adjustments for performance in reducing clostridium difficile	E/clause 44

NHS Standard Contract for Ambulance Services – Conversion Table

Clauses 1-60 and Schedule 1

Clause in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract[6]
1	Definitions and Interpretations	1
2	Commencement, Duration and Transition	A/clause 4, C/3, E/clause 4
3	Commissioner and Representatives	48
4	Services	
	Service Provision	5
	Withholding and/or Discontinuation of Service	21
	Business and Service Continuity	16 and 49
	Miscellaneous	38, 11, 17, 33 and 42
	Service Development and Improvement Plan	29
4A	Safeguarding Children and Adults in Vulnerable Circumstances	24
5	Services Environment, Vehicles and Equipment	22
6	Co-operation	18
7	Prices and Payment	7
8	Review	46
9	Consent	26
10	Complaints	27
11	Staff	23
12	Clinical and Planning Networks	35
13	Not used	-
14	Death of a Patient	28
15	Serious Untoward Incident and Patient Safety Incident Reporting	25
16	Quality, Patient Safety and Quality Improvements	6
17	Procedures and Protocols	34
18	Transfer and Discharge from Care Obligations	17 and Section C, Part 6D
19	Governance, Transaction Records and Audit	54
20	Managing Activity and Referrals	41
21	Patient Health Records	13
22	Confidential Information of the Parties	59
23	Intellectual Property	62
24	NHS Branding, Marketing and Promotion	61
25	Pastoral, Spiritual and Cultural Care	20
26	Liability and Indemnity	50

[6] Except as otherwise expressly indicated references in this column are to clause numbers in Section E.

27	Data Protection and Freedom of Information	60
28	Dispute Resolution	53
29	Information Requirements	39
30	Not used	-
31	Service Standards	40
32	Performance Management	47
33	Service Quality Review	45
34	Suspension	55
35	Termination	56
36	Consequences of Expiry or Termination	57
37	Prohibited Acts	65
38	Variations	52
39	Warranties	64
40	Notices	75
41	Force Majeure	67
42	Major Incidents	36
43	NHS Counter-Fraud and Security Management	37
44	Third Party Rights	68
45	Waiver	71
46	Entire Agreement	69
47	Severability	70
48	Assignment and Sub-contracting	51
49	Change in Control	63
50	Exclusion of Partnership	73
51	Non-Solicitation	74
52	Provisions Surviving Termination	58
53	Conflicts of Interest	66
54	Equity of Access, Equality and No Discrimination	19
55	Non-Contract Activity	7
56	Compliance with the Law	76
57	Counterparts	78
58	Remedies	72
59	Costs and Expenses	77
60	Governing Law and Jurisdiction	79
Schedule 1	Definitions and Interpretations	Schedule 1

Schedules 2-20

Schedule/Part in 2011/12 NHS Standard Contract	Heading	Position in 2012/13 NHS Standard Contract
2	The Services	
2/1	Service Specifications	B/1
2/2	Emergency Preparedness and Hazardous Area Response	E/clause 336
2/3	Transfer of and Discharge from Care Protocol	C/7.1

2/4	Essential Services	B/2
2/5	Additional Services	-
3	Monitoring Demand and Retention of Payment Scheme	
3/1	Managing Activity	E/clause 41
	Activity Plan	B/3
	Contents and Thresholds	-
	Monitoring and Reporting of Activity	E/clause 41
	Activity management following activity variations	E/clause 41
	Financial Adjustment for Variations in Activity	E/clause 41
	Capacity Review	-
3/2	Not used	-
3/3	Patient, Carer and Staff Experience and Other Surveys	B/12
3/4	Quality Requirements and Nationally Specified Events	B/9
3/4A	Quality Requirements	B/8.1
3/4B	Nationally Specified Events	B/8.2
3/4C	Never Events	B/8.3
4	Transition	
4/1	Conditions Precedent	C/1
4/2	Longstop Date	A/clause 5
4/3	Transition Arrangements	C/3 and E/clause 4
5	Information Requirements	
5/1	Mandatory National Requirements	B/14.1
5/2	National Requirements for Local Definition	B/14.2
5/3	Local Requirements	B/14.3
6	Service Variations, National Variations and Other Variations	
6/1	Variation Procedure	E/clause 52
6/2	Recorded Variations and Dispute Resolution	D/1 and D/3.1
7	Service Development and Improvement Plan	B/11
8	Agreements relating to Termination Costs	C/11
9	Dispute Resolution Procedure for Disputes between divisions of the same NHS Body	D/3.3
10	Provider's Material Sub-Contractors	C/5
11	Consortium Agreement and	

	Commissioning Intentions	
11/1	Consortium Agreement	C/9
11/2	Commissioning Intentions	B/4
11/3	Notices to Aggregate/Disaggregate Payments	D/2
11/4	NHS/Local Authority Partnering	E/clause 38
11/5	Policy for Safeguarding Children and Adults in Vulnerable Circumstances	C/7.2
11/6	Associates	A/clause 7
12	Serious Untoward Incidents and Patient Safety Incidents	C/7.3
13	NHS Counter-Fraud and Security Management	
13/1	NHS Counter-Fraud and Security Management for Non-NHS Providers	E/clause 37
13/2	NHS Counter-Fraud and Security Management for NHS Providers	E/clause 37
14	Documents Relied On	C/4
15	Change in Control Notification Pro Forma	D/4
16	Intellectual Property	
16/1	Provider IPR	C/8.2
16/2	Commissioner IPR	C/8.1
17	Notices	A/clause 8
18	Quality Performance Incentive Schemes	
18/1	Nationally Mandated Incentive Schemes	B/9.1
18/2	National Incentive Framework	B/9.2
18/3	Locally Agreed Incentive Schemes	B/9.3
19	Not used	-
20	Clinical and Planning Networks	B/13
21	Provisions that May be varied	E/Schedule 1

Annex three: non-mandatory mental health quality requirements

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	People with a learning disability/ASC or long-term mental illness should receive appropriate physical health care • All service users who have been in hospital/long-term health care for more than one year should have a physical health check at least annually [Non-mandatory- insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
	Acute hospitals should have access to high quality psychiatric liaison services (ward and emergency care settings), including ward-based services for older people • Comprehensive psychiatric liaison service is in place in all acute hospitals [Non-mandatory- insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
	People with	[Insert as per	[Insert as per	[Insert as per

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	complex needs or who need additional support to stay in contact with services should have access to a local assertive outreach service • Comprehensive coverage of the population by assertive outreach services which meet national standards [Non-mandatory- insert as per local determination]	local determination]	local determination]	local determination]
	Dementia should be diagnosed as early in the illness as possible • Comprehensive coverage of the population by early intervention in dementia services which meet national objectives [Non-mandatory- insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
	All children and young people, including children with learning disabilities and/or ASC, should have access to a local comprehensive child and adolescent mental	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	health service (CAMHS) • Comprehensive coverage of the population by comprehensive CAMHS, which include access to 24-hour cover for urgent needs [Non-mandatory- insert as per local determination]			
	Prisoners with mental disorder including LD and/or ASC should receive appropriate input from specialist services post release (relevant providers only) • Prison mental health in-reach services should cover arrangements for follow-up post release [Non-mandatory- insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
	Prisoners who need access to an NHS bed for specialist mental health care should be transferred as soon as is possible • Reduction in waiting times for transfer from prison to NHS bed	[INon-mandatory- insert as per local determination] Once service established, local plan to be agreed to achieve referral to transfer from prison to mental	[Insert as per local determination]	[Insert as per local determination]

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	[Non-mandatory- insert as per local determination]	health bed for individuals under Section 47/48 of the MH Act within 14 calendar days • Recording of time from referral to acceptance of prisoner for care to actual transfer to an NHS bed • Recording section 117/CPA pre-discharge meeting prior to remittance • Recording of remittance to prison		
	People with a mental disorder should have their needs assessed and should be diverted from the criminal justice system (CJS) whenever appropriate • Comprehensive coverage of the population by timely and appropriate CJS assessment and diversion services [Non-mandatory- insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
	People with a dual diagnosis of mental	[Insert as per local		

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	illness, personality disorder, LD or ASC and a drug or alcohol problem should receive an assessment of all their needs and an appropriate package of care Local services should have staff with appropriate skills to both assess and manage those with dual diagnosis – this will be reflected in care plans that address all the service users needs [Non-mandatory- insert as per local determination]	determination]		
	Current and former substance misusing clients should be assessed, and, where possible, treated and/or vaccinated for blood borne viruses All Service Users to receive general healthcare assessment All Service Users to be offered Hepatitis B vaccination All current or previous injectors to be offered Hepatitis C testing (and subsequent	[Insert as per local determination]		

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	treatment) [Non-mandatory- insert as per local determination]			