NHS England

NHS Standard Contract for 2015/16

Discussion paper for stakeholders response document

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This document is provided for you to use when providing your comments on the NHS Standard Contract for 2015/16 discussion paper for stakeholders. Please expand the response boxes as required.

Please send your comments, by Friday 12 September 2014, to: england.contractsengagement@nhs.net

Details of person completing this response document

Name and job title	Ben Cook, Deputy Head of Public Affairs
Organisation	The Optical Confederation and the Local Optical Committee Support Unit
Email	bencook@opticalconfederation.org.uk
Phone	020 7298 5100

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Key issues on which we would welcome feedback

Key issue 1 The Contract as a commissioning lever

Question 1 *To what extent should the NHS Standard Contract be used to support longer term strategic changes in local health systems?* *Would you propose any specific changes to the NHS Standard Contract to strengthen the ability of commissioners to use it to support the longer term strategic direction in local health systems?*
The NHS Standard Contract is a useful tool in moving appropriate secondary care services into primary care, but with the caveat of our response below to the second part of this question. In order to support the development of more out of hospital services we recommend that a 'reduced' version of the contract should be developed for small-scale services that can be service specific. Low risk services that that can be delivered in a uniform way nationally are ideal services to be commissioned through a National Standard Contract – reducing transaction costs, consuming less commissioning resources, minimising clinician confusion and avoiding a postcode lottery for patients. This

would allow patients access to the same high quality service regardless of where they live and allow providers to invest more resources in delivering care and better health outcomes.

Key issue 2 Changes made to the Contract for 2014/15

Question 2

How are the changes we made for 2014/15 working in practice?

Have they delivered benefits?

Have they caused any problems in practical implementation?

We welcome the review of the applicability of a range of clauses within the Service Conditions to particular service types, and the changes made where NHS England, like us, felt the contract placed an unrealistic and excessive burden on providers of certain services. However, we have found a lack of understanding regarding exemptions for small providers and providers of community services amongst Commissioning Support Units (CSUs).

We also welcome the development of the online electronic contract system (the eContract), launched for 2013/14, and the flexibility it gives commissioners to adjust the content of the Service Conditions and Particulars – so that text which is not relevant to the provider or the services to be delivered is excluded. However, of the numerous contracts for community services issued during 2013/14 (and into 2014/15) which we have reviewed, there is very little evidence of the eContract being used. The fact that most CSUs continued to use the paper contract, and an apparent lack of knowledge and expertise within CSUs, resulted in the inclusion of inappropriate clauses or quality and reporting requirements in most of the NHS standard contracts for community eye care services produced by CSUs to date. This inefficient approach means that unnecessary lengthy discussions and negotiations have been required to get such clauses or quality and requirements removed.

There are also issues with the *"Applicable service categories"* for some of the Never Events in Schedule 4D, and it is our understanding that CSUs are not able to remove or amend these even when they understand a Never Event is not in fact applicable to a particular service. For example, under Medication, *"Wrongly prepared high-risk injectable medication"* and *"Wrong route administration of oral/enteral treatment "* state *"All except PT",* however, community eye care services provided by optometrists do not involve injectable medication or oral/enteral treatment. Similarly, under General Healthcare "*Falls from unrestricted windows"* and *"Misplaced naso- or oro-gastric tubes"* should not be applied to contracts with community optical practices or other similar providers. CSUs need flexibility to be able to set the requirements to fit the type or service and provider.

Further training and guidance for CSU staff and Clinical Commissioning Group (CCG) contracts managers on how to apply the NHS Standard Contract to different types of services and providers is required.

We welcome, under SC36.31 and SC36.32, the duty bestowed upon the commissioner to pay small provider reconciliation accounts and/or invoices within ten Operational Days. The Technical Guidance for the 2014/15 advises that this is an

important provision to help small provider organisations to avoid cashflow difficulties, and commissioners should take steps to ensure that their local providers are being paid in accordance with this timescale. We are extremely disappointed to report therefore that payments by commissioners to providers of community eye care services have rarely been made within the timescale set out by NHS England and that delays of two or more months are commonplace. We urge NHS England to provide clarity for providers regarding who to complain to when payments are delayed. In our experience, CCGs often blame CSUs or NHS Shares Business Services (NHS SBS), and vice versa, leaving the provider in the dark.

Key issue 3 Mandated use of the NHS Standard Contract

Question 3

Are commissioners now routinely using the NHS Standard Contract for all their commissioned healthcare services other than primary care?

If not, for which services are locally-designed contracts still being used?

Are there specific problems with the format or content of the Standard Contract which are causing this?

A number of CCGs have carried on with locally designed contracts or service level agreements for previously commissioned community eye care services as they consider that the nature of the NHS Standard Contract is disproportionate to the service(s) being provided, particularly as optical practices providing the service(s) already have a General Ophthalmic Services (GOS) contract with NHS England. For services such as cataract referral refinement, glaucoma repeat readings and assessing and managing minor eye conditions, CCGs see the work to move services across to the NHS Standard Contract as unnecessarily time-consuming and bureaucratic.

As outlined in our response to the NHS Standard Contract consultation carried out by NHS England 12 months ago, we want to see national pathways and service specifications for community eye care services, underpinned by a proportionate and tailored standard national contract. This will ensure consistency of standards and quality. A national standard for each community eye care service based on the national pathways developed by LOCSU would be welcomed.

As explained in our response to Question 1 we recommend that a ‘reduced’ version of the contract should be developed for small-scale services, such as community eye care services. Low risk services that can be delivered in a uniform way nationally are ideal services to be commissioned through a National Standard Contract – reducing transaction costs, consuming less commissioning resources, minimising clinician confusion and avoiding a postcode lottery for patients. This would allow patients to access the same high quality service regardless of where they live and allow providers to invest more resources in delivering care and eye health outcomes than

in dealing with the complexities of local variations.

LOCSU and the Optical Confederation would be willing to support NHS England in reviewing the current system and working on a more innovative and cost-effective approach to contracting for community eye care services in England. We will be including these recommendations in our response to NHS England's *Call to Action – Improving eye health and reducing sight loss.*

Key issue 4 Tailoring the contract for different service types

Question 4

Are there conditions within the Contract which are inappropriate or redundant for particular service types?

Where would alternate provisions be appropriate, and where would the omission of particular provisions be appropriate, because they do not add value?

There are many conditions within the Contract that are inappropriate or redundant for community eye care services contracts. As noted in our response to Question 3, we want to see a proportionate and tailored standard national contract for community eye care services with national pathways and service specifications.

A few examples of conditions that are inappropriate for providers of community eye care services and other similar providers are:

GC5.2 – a number of the sub-clauses do not reflect the fact that the service provided under the contract represents only a fraction of the work carried out by an optical practice (often seeing only a handful of patients per week). It is not necessary or appropriate for the provider to consider the staffing for the commissioned service separately to the rest of his business.

GC5.9 – Staff Surveys – see comment above.

GC5.13 – 5.17 -TUPE would not normally apply to community eye care services.

SC6 – community optical practices do not currently have access to *Choose and Book*.

SC11 – some of the Transfer of and Discharge from Care sub-clauses are overly complex or redundant for community eye care services.

SC23.5 – community optical practices do not have access to NHS numbers.

SC28 – many of the sub-clauses are redundant for community eye care services.

Also, as noted in our response to Question 2, there are issues with the *"Applicable service categories"* for some of the Never Events in Schedule 4D of the *Contract Particulars*. For example, under Medication, *"Wrongly prepared high-risk injectable medication"* and *"Wrong route administration of oral/enteral treatment "* state *"All except PT",* however, community eye care services provided by optometrists do not involve injectable medication or oral/enteral treatment. Similarly, under General Healthcare "*Falls from unrestricted windows"* and *"Misplaced naso- or oro-gastric tubes"* should not be applied to contracts with community optical practices or other similar providers. CSUs need flexibility to be able to set the requirements to fit the type or service and provider.

Key issue 5 NHS England as direct commissioner

Question 5 *Would it be clearer if certain national requirements of NHS England as direct commissioner of services were built into the nationally-mandated text of the NHS Standard Contract (but perhaps to be included or excluded by appropriate selection of option via the eContract system)?*
This should only be considered if the eContract is mandatory and staff are trained accordingly.

Key issue 6 **Grant agreements**

Question 6 *Would commissioners welcome publication by NHS England of a model grant agreement template?* *Do you have a form of grant agreement which you have used successfully with voluntary sector providers which you would be happy to share with us?*
N/A

Key issue 7 **Contract management (General Condition 9) and financial sanctions**

Question 7 *Do commissioners use the Contract Management provisions in practice?* *Do these work effectively?* *Do the potential financial sanctions in the Contract Management process act as an effective incentive for providers to remedy poor performance?* *Are sanctions pitched at an appropriate level?* *Is there a need for further non-financial levers, aligning commissioner powers under the Contract with action by regulators?*
Our experience is that commissioners need more support to become fully familiar with the current contract management processes. Our experience is that local commissioners are struggling to establish robust and reliable performance management mechanisms. Therefore we feel more support is needed to help commissioners apply the Standard Contract in the areas of contract management, dispute resolution and managing activity and referrals. We are willing to help with this for the benefit of all especially patients and the public.

Key issue 8 **Never Events**

Question 8 *Would you support changing the focus of Never Event sanctions for 2015/16, to focus on dis-incentivising failure by providers to report Never Events?*
In principle we would support changing the focus of Never Event sanctions for 2015/16, to focus on dis-incentivising failure by providers to report Never Events. However, the "*Applicable service categories"* for individual Never Events must be reviewed to ensure that they are applied only to services to which they are relevant.

Key issue 9 **Sub-contracting (General Condition 12)**

Question 9 *What would constitute a proportionate approach to commissioners having oversight of provider sub-contracting arrangements?* *Are the expectations in the current Contract on sub-contracting unreasonable or unrealistic – and, if so, why?* *Should we review and clarify our definitions and guidance on sub-contracting?* *We have received requests to publish a non-mandatory template for sub-contracts – would this be helpful?*
The onus is on the Prime Contractor to deliver the service and achieve all the quality etc. standards of the Standard Contract and it is up to the Prime Contractor to contract with and manage its sub-contractors to ensure that the Prime Contractor complies with its own responsibilities. In our view a non-mandatory template for sub-contracts is not required as it may well end up as mandatory and could unreasonably fetter the right of Prime Contractors in their dealings with their sub-contractors.

Key issue 10 **Dispute resolution (General Condition 14)**

Question 10 *How frequently do commissioners and providers follow the formal dispute resolution process – or are they usually able to resolve in-year differences informally?* *Is the process of Expert Determination set out in the Contract workable in practice?* *Is there sufficient clarity about the basis on which disputes relating to the agreement of a new contract should be handled?* *Would further national guidance in this area be helpful?*
We have not experienced the dispute resolution process set out in the NHS Standard Contract so are unable to comment.

Key issue 11 **Managing activity and referrals (Service Condition 29)**

Question 11 *Do commissioners use the activity management provisions in SC29 in practice?* *Are there some service types for which the provisions are simply not relevant at all?* *Do the provisions strike the right balance between commissioner and provider responsibilities and create strong enough incentives for each?*
We have seen little use of the activity management provisions in SC29 by commissioners, to date, for community eye care services. This is largely due to the complex nature of the process proposed. We would welcome a more simple process for community services. The activity management provisions are not relevant for Any Qualified Provider (AQP) services as there is no guaranteed activity for the provider.

Key issue 12 Information flows, payment and financial reconciliation

Question 12 *Are any specific aspects of information, payment and reconciliation processes set out in the contract unclear?* *Is the overall reporting burden appropriate?* *Do the nationally-mandated Reporting Requirements in Schedule 6B cover all of the core information which commissioners require for any contract?* *Is there a case for including a specific requirement in the Contract so that any claim for a provider for payment must be backed by datasets at individual patient level?*
As explained in our answer to Question 2, payments by commissioners to providers of community eye care services have rarely been made within the timescale set out by NHS England and delays of two or more months are commonplace. In our experience CCGs often blame CSUs or NHS SBS, and vice versa, leaving the provider in the dark. A number of CCGs/CSUs are already insisting that claims for payment are backed by datasets of individual patients. This is an onerous requirement on providers and is a particular issue for optical practices as they do not have access to NHS numbers. It is also a significant administrative burden for commissioners. Provision to allow practice records to be inspected by commissioners on request for Post-Payment Verification (PPV) purposes would be more proportionate

Key issue 13 The electronic contract system

Question 13 *What would encourage you to make greater use of the eContract system?* *Is the key requirement to have a basic system which works reliably from the start of the contracting round?*
We are not commissioners or contract managers, however, we have worked with numerous CCG and CSU colleagues who have struggled with the paper contract and the eContract, and would stress that a system which works reliably is essential. We feel that the only way to ensure that the eContract is used is to make its use mandatory. Training for users is vital. We also recommend that further training for CSUs and CCGs on the content of the NHS Standard Contract, and its relevance to different types of services and

providers, is crucial to significantly reduce the time being wasted due to the current lack of experience and expertise. This must be prioritised to bring efficiency to the commissioning process both for commissioners and providers.

Key issue 14 Staff engagement and equality

Question 14 *Would you support the additions and amendments to the NHS Standard Contract for 2015/16 (as detailed in s3.14 of the NHS Standard Contract for 2015/16 Discussion paper for stakeholders)?*
Although we support the need for providers to respect equality and human rights of staff, service users, carers and the public, we are concerned that mandating the Equality Delivery System (EDS) would create a further unsustainable burden for small providers. We urge NHS England to consider a small provider exemption.

Key issue 15 Minimising redundancy costs when senior NHS staff are subsequently re-employed

Question 15 *How could the NHS Standard Contract be used to create appropriate incentives for providers and commissioners, in terms of the re-hiring of senior NHS staff in receipt of redundancy pay from their previous NHS employer?*
In principal we support steps to address this issue.

Key issue 16 Contract support from NHS England

Question 16 *How can the NHS Standard Contract team better support commissioners and providers using the Contract at local level?* *In particular, how useful is our Contract Technical Guidance, and do you have suggestions for additional topics which need to be covered in it?*
The Technical Guidance is useful but as indicated in our responses to earlier questions, further training for CSUs and CCGs on the content of the NHS Standard Contract and its relevance to different types of services and providers, is crucial to significantly reduce the time being wasted due to the current lack of experience and expertise.

Other issues

Question 17 *We are happy to receive suggestions for improvement to any other aspects of the NHS Standard Contract. Please feel free to cover further topics here.*
We would like to reiterate our recommendation that NHS England should develop a proportionate and tailored Standard National Contract with national pathways and service specifications for community eye care services. A number of CCGs have carried on with locally designed contracts or service level agreements for previously commissioned community eye care services as they consider that the nature of the NHS Standard Contract is disproportionate to the service(s) being provided particularly as optical practices providing the service(s) already have a GOS contract with NHS England. For services such as cataract referral refinement, glaucoma repeat readings and assessing and managing minor eye conditions, CCGs see the work to move services across to the NHS Standard Contract as unnecessarily time-consuming and bureaucratic. To ensure consistency of standards and quality, we want to see a national standard for each community eye care service based on the national pathways developed by LOCSU. For more details, please follow the link: http://www.locsu.co.uk/community-services-pathways/ LOCSU and the Optical Confederation would be willing to support NHS England in reviewing the current system and working on a more innovative and cost-effective approach to contracting for community eye care services in England.

How to respond

Please send the completed response document, by Friday 12 September 2014, to: england.contractsengagement@nhs.net