Using the NHS Standard Contract effectively

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Introduction

- How the NHS Standard Contract may be used effectively highlighting:
  - both pitfalls to be avoided; and
  - how it may be adapted for use for delivery of integrated services
- Other “important” NHS Standard Contracts

Structure of NHS Standard Contract

- Three parts:
  - the Particulars (all locally agreed details go in here, for example, details of the parties, the service specifications and schedules relating to payment)
  - Service Conditions (SCs)
  - General Conditions (GCs)
- SCs and GCs may not be amended (although some parts only apply to some services)
- Particulars must not be used to vary SCs or GCs

Order of Priority (GC1)

- Clause (GC1)
  - General conditions
  - Service Conditions
  - Particulars
  - All trump Commissioner Documents, Documents Relied on and Local Agreements and Policies
- Docs Relied On for side letters/heads of agreement that cut across the mandated provisions will not be enforceable!
- As the Particulars provide the framework of your locally agreed deal, today we will focus on key elements of them and related SCs and GCs

Parties to the NHS Contract

- The Contract may only be with a single Provider but may be multiple commissioners
- General prohibition on assignment and subcontracting by Providers, except to:
  - Mandatory Material Subcontractors
  - Permitted Material Subcontractors (Remember to complete Schedule 5 Part B1 & B2)
- Regardless of number of sub-contractors, commissioner can hold the lead provider to account for all services under the lead contract.

Use of and key elements of the NHS Standard Contract

Key things to consider

- Choice of contract
- Contract Term – consider in context of your project
- Services Commencement, Transitional Arrangements /Mobilisation Phase, Conditions Precedent
- Careful management of contract extensions/variations
- Careful design of:
  - Service Specifications
  - Indicative Activity Plans
  - Local Quality and Reporting Requirements
  - Local Prices/Expected Annual Contract Value & payment model
  - CQUIN/Local Incentive Scheme
  - SDIP

  Use of a collaborative commissioning agreement – economies of scale

Contract Term

- If the aim of the proposed contract is to deliver integrated services and improve quality then a longer term contract likely to be appropriate:
  - probably with a mobilisation period before service commencement; and
  - use lengthy Commissioner and Provider Earliest Termination Dates (at least 12 months) to reassure Provider that investing upfront is worthwhile (so in effect operate as “break clauses”)

Extensions and variations

- Schedule 1C (optional) allows the commissioner to extend the contract term as specified but only as previously advertised.
- Any variations must take account of the Public Contracts Regulations 2015. For example if contract is:
  - intended to cover other services in the future – this needs to be clear in the advertisement; or
  - Innovative: limit circumstances when may be varied

Conditions Precedent (CP)

- CPs are things which Provider must do, or documents which it must provide to establish to the satisfaction of the Co-ordinating Commissioner that it is ready and able to start providing the Services as required by the Contract
  - E.g. Evidence of CQC registration of Provider and Material Sub-Contractors
- Schedule 1A - list CPs that apply in all cases and also CPs that may apply (in square brackets)

Conditions Precedent (Cont'd)

- If C is using NHS Standard Contract to provide an integrated service for example, it may want to make the it a CP that P provides C with all Permitted Material Sub-Contracts signed and dated.
- Sch 1C often mistaken for a "to do" list for later -allowing Contract to be signed while parking contentious issues for later date.
- C may terminate Contract C if CPs not satisfied by date specified for satisfaction, (GC 17.10.1).

Transitional Arrangements (Schedule 2H)

- Parties may set out in Sch 2H actions that they both must take to ensure continuity of service and orderly transition from old to new provider
- Sch 2H often used as a “mobilisation period” with obligations being placed on both providers and commissioners to be performed in the period between contract signature and Service Commencement Date. For example, the Provider must agree all Permitted Material Mandatory Sub-contracts.

Transitional Arrangements (Cont'd)

- Overlap between CP and Transitional Arrangements
- Can make the performance by the provider of Transitional Arrangements (unless waived by the Commissioner) a CP to ensure that if the provider does not carry out those actions the commissioner may terminate the Contract
- Do need to police performance during mobilisation (particularly meeting mobilisation milestones) otherwise just postponing problems until later

Other Agreements, Policies & Procedures & Docs Relied On

- Use Schedule 2G (Other Agreements, Policies and Procedures) and Schedule 5 Part A Provider or Part B Commissioner (Documents Relied on) to record agreements reached on additional matters
- Schedule 2G – if using a Risk/Gain Share Agreement consider including here
- Schedule 5 Parts A (Provider) & B (Commissioner) (Documents relied on)

Exit Arrangements – Sch 21

- Optional – parties may decide to rely on GC18 (Consequences of termination) and GC5 TUPE
- GC18 - liability, co-operation, provision of information/assistance, succession plan, survival of terms etc
- Consider if any “Exit Arrangements” should be included, for example redundancy costs. P may also look for exit payments from C, if C terminates at will, to cover termination losses/costs P incurs.

Services and Quality Overview

Overview

- SC1: Provider must provide Services in accordance with the **terms of this Contract, the Law and Good Practice**
- SC1: Parties to **"abide by"** and **"promote awareness of"** the **NHS Constitution** – requirement to abide now extends to sub-contractors and staff
- SC3: Provider must meet **Quality Requirements, Operational Standards**, ensure **Never Events** do not occur.
- GC 5 – clear requirements for staffing levels and continual review (every 6 months)

Services and Quality Overview (cont'd)

- Sch 2: Service Specification –
- Specification is essential to **hold providers to account**
- An **increasing emphasis on outcomes**
- Sch 4: Quality Requirements – **Operational Standards, National QRs, Local QRs, CQUIN and Local Incentive Schemes**
- Can agree consequences for breach of Local QRs (up to 2.5% of Actual Quarterly Value) or alternatively could include LQRs local incentive scheme – effect being to incentivise to achieve outcomes rather than applying a sanction for failure.

Linking Specs to QRs, Info Reqs, Incentives

- QRs and Reporting/Info Requirements inextricably linked to Service Specifications but should not be included in them
- QRs and incentive scheme metrics should be based on factors that go to key outcomes
- Reporting/Information Requirements should be measuring those things
- QRs and Reporting/Info Requirements form the **baseline requirements** and incentive scheme metrics form stretch goals

Common issues with Service Specifications

- Not really a specification – just a list of health resource groups or everything that is known about a particular service
- Should at least specify the service name, access criteria and key outcomes required
- Not clear what is in or out of scope
  - Risk for the commissioner – provider may refuse to provide service or only at extra cost

Common issues with Service Specifications (Cont'd)

  - Risk for provider if C's requirements are more than anticipated, P cannot refuse to do extra work because specification is unclear
- Specification should be a composite of C's requirements and how P intends to meet them. If get one or the other only – lack of clarity.
- Outcomes expressed in vague manner not supported by clear measures and/or indicators

Common issues with Service Specifications (Cont'd)

- Schedule 2A includes a non-mandatory model template for local population. Cs can either use the structure of the template or can determine their own in accordance with the NHS Standard Contract Technical Guidance.
- This flexibility, provides scope for composite specifications (see earlier) and also means that Service Specification can be tailored to meet requirements specific to integrated services.

Indicative Activity Plans and Activity Planning Assumptions

- SC 29.5 – 6: Parties agree IAP specifying threshold for each activity. If no agreement, default position is activity level of zero
- SC 29.7: CC must notify P of APAs, they must be set out in the contract at Partics Sch 2C and P must comply
- Reminder: what are APAs?
  - Things like consultant to consultant referrals, new to follow up ratios, etc.
  - Expected external demand/how referrals are managed once accepted

Indicative Activity Plans and Activity Planning Assumptions (cont'd)

- Reminder: IAP is indicative and not binding, so why is it important?
  - Affects level of payments to providers (1/12th value of Expected Annual Contract Value paid in advance), subject to reconciliation
  - Activity over levels specified in IAP triggers **activity management process**

Payment

- Payment – Schedule 3
- Schedule 3A – Local Prices for where no National Price (details of basis for payment: block payment, activity based, quality or outcomes **and where contracts span multiple years details of annual price adjustment**)
- Schedule 3B/C – Local Variations (LVs) (decreases)and Local Modifications (LMs) (increases) to National Prices (completed publication templates required by Monitor)

Payment (Cont'd)

- LVs -must be agreed by parties, abide by local principles and notify Monitor
- LMs – by agreement/application to Monitor and decision notice to be attached and in accordance with National Tariff Rules

- Schedule 3F - Expected Annual Contract Value
- Include annual adjustments to EACV

Payment (Cont'd)

- Can use Schedule 3F to show how Annual Contract Value is arrived at and percentage of which may be outcomes payment or CQUIN payment payable on achievement of outcomes and how such outcomes payments are to be made. E.g May pay percentage on account, withholding balance until annual reconciliation

Incentive Schemes

- Sch 4E – Local Schemes
  - 2An optional additional incentive (Local Quality Requirements/Quality Incentive Scheme Indicators)
  - Can be used locally to good effect to improve quality
  - Can now be used as an alternative or addition to CQUIN in line with CQUIN guidance
  - See “Payment” earlier for how may used to incentivise Ps
  - If affect services covered by National Prices may need to submit a Local Variation to Monitor
  - Form an annual ‘Service Variation’

SDIP (Schedule 6E)

- SDIPs record action which P will take, or which the Parties will take jointly, to deliver specific improvements to the services or to transform them
- SDIPS about developing services beyond the currently agreed standard
  - Agreed productivity and efficiency plans
  - Service re-design programmes
  - Priority areas for quality improvement
- Consider what SDIPs to include and when. E.g could include a SDIP of implementing a workforce strategy

Other NHS Standard Contracts

Other NHS Standard Contracts

- NHS Standard Contract 2017-19 (Shorter Form)
- NHS Standard Sub-contract for the Provision of Clinical Services (full length and shorter form)
- Draft ICP Contract
- NHS Standard Contract Template Alliance Agreement

Draft ICP Contract

- Consultation - 3 August until 26 October 2018
- ICP Contract can also only be entered into by a single provider
- Proposed ICP Contract:
  - designed to underpin integration between services; and
  - differs from the existing NHS Standard Contract

Key features – alliance contracting

- A contract between C and alliance of Ps to deliver integrated service – same objectives, same shared risks and gains.
- Parties agree objectives together and align their own contractual objectives with the overall project objective
- Share risk – each party takes a risk share for something beyond its control and/or each party has a stake in the success of others
- Contracting for outcomes
- Expectation of innovation
- Change in traditional behaviour

Questions

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Thank you!