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GUIDANCE **01**-2009

Guidance on the Standard NHS Contract for Acute Hospital Services for the NHS in England 2009-10 – Part 1

1. Introduction

This document provides guidance for NHS commissioners and service providers in England on the updated standard contract introduced from April 2009.

What is the Contract?

The NHS Contract for Acute Hospital Services ('the Contract') will cover agreements between Primary Care Trusts (PCTs) and providers of acute hospital-based care ('providers').

The Contract is a standard, not a model, contract. A standard approach to contracting for NHS services was first proposed in *Health reform in England: update and commissioning framework* (July 2006). It has been introduced as an important part of the arrangements for managing the reformed NHS system. It will improve NHS business processes and support the development of world class commissioning.

The range of contracts and service level agreements which the Contract replaces were not fit for purpose in an environment of a greater plurality of provision, more autonomous providers, and the ability of any willing provider to offer elective treatment in a system without volume constraints. The Contract will support the achievement of key standards and targets and ensure that commissioners and providers do not become financially exposed.

The Contract creates legally binding agreements between PCTs and Foundation Trusts (FTs), and between PCTs and independent and third sector providers. Agreements between PCTs and NHS Trusts will be in exactly the same form and treated with the same degree of rigour and seriousness as if they were legally binding.

The first version of the Contract was introduced for 2008-09 and applied to NHS Trusts and NHS FTs only. Since then the Contract has been further refined to learn lessons from the way in which the first version was used. It is intended that the independent and third sectors will use this updated Contract from April 2009.

Following the introduction of the interim and first versions of the Contract, the process of developing this Contract was overseen by a national steering group comprising Department of Health (DH) officials and Strategic Health Authority (SHA) Directors of Commissioning. A stakeholder reference group also advised on, supported and challenged the development process and content.

This group was comprised of representatives from:

- the NHS Confederation and its networks – the FT Network, the PCT Network and the NHS Partners Network
- the third sector
- Monitor
- NHS Trusts

Who will use the Contract?

From April 2009 the revised Contract and this Guidance will apply to agreements made by PCTs with the following providers of acute services:

- all NHS Trusts
- NHS FTs – all new FTs and existing FTs whose contracts expire by 31 March 2009 will adopt the contract. FTs whose contracts extend beyond March 2009 may choose to adopt the Contract or retain their existing contracts until the required period of notice to change has expired
- independent and third sector (IS) – it is the intention that the IS wishing to contract for NHS funded services will transfer to the Contract. The coordinating commissioners and IS providers will work together supported by the DH to effect this change. Contracts that expire on 31 March 2009 will use this Contract from April 2009. Those IS providers whose contracts extend beyond March 2009 may, subject to agreement, choose to adopt the Contract or retain their existing contracts until the required period of notice to change has expired

Specialised services commissioning groups will use the Contract, adapted as necessary, for their agreements with providers of specialised services.

Practices – or consortia of practices – which wish to provide secondary care-type services will normally be able to do so within the terms of their primary care contracts (eg GMS, PMS, APMS or SPMS contracts). However, under certain circumstances it will be more appropriate for PCTs to contract for such services using the Standard NHS Contract.

The Commissioning Framework and practice based commissioning (PBC) Guidance set out the procurement requirements for PBC. They are reinforced by the Principles and Rules for Cooperation and Competition published alongside this Contract, and the forthcoming Procurement Guide will provide further guidance – but, broadly, the Standard NHS Contract should normally be used if one of the following criteria applies:

- the service has been procured through open tendering and is delivered by a commercial vehicle such as a limited company
- the service is provided to a population greater than that of a single practice and is a monopoly service, ie the only such service within the PCT area
- the service has been transferred on a like-for-like basis from a hospital setting and is covered by the Payment by Results (PbR) Tariff

In applying these criteria PCTs should consider whether the use of the Contract is proportionate to the scale of the service and should ensure that the requirement to use the Contract does not stifle innovation.

2. Aims and principles

The Contract provides an important tool for assuring accountability between providers and PCTs and for improving performance.

All providers and PCTs are obliged under the Contract to have regard to the NHS Principles (published in *The NHS Plan* (2000) and subject to amendment by the Secretary of State from time to time).

Subject to the outcome of the consultation exercise and the passage of legislation, all providers will be obliged to have regard to the requirements of the NHS Constitution.

The members of the Contract stakeholder reference group agreed a set of guiding principles put forward by the FT Network, the PCT Network and the Mental Health Network for the development of the Contract, requiring 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 cooperation and collaborative behaviours that benefit all parties and cement the positive relationship between them
- be based on terms that are deliverable in practice

Stakeholders also agreed that the following behaviours should be expected of providers and PCTs 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 penalties
- recognise the investment required to achieve requirements over a reasonable time period
- support providers in changing 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

PCTs and providers will be required to comply with the Code of Conduct for PbR and with applicable Department of Health PbR guidance. For services to which the National Tariff does not apply, the provider and the relevant coordinating commissioner will agree non-Tariff prices.

PCTs and providers will be expected to behave in accordance with the *Principles and Rules for Cooperation and Competition*. Any SHA-led commissioning rules or requirements must also be consistent with these principles and rules.

The Contract will enable patients to choose where they are referred for elective care, and providers will be paid by PCTs according to PbR rules for the work they do. Providers will be expected to manage their capacity flexibly to accommodate the choice of provider that patients make.

The goal is to achieve genuine agreements for all providers, ahead of the start of the financial year, about the volume and flow of acute hospital activity.

All providers and PCTs are required to agree an Activity Plan as described in Schedule 3 of the Contract. Once agreed, Activity Plans are expected to be achieved.

Where required, providers and coordinating commissioners must agree Prior Approval and Utilisation Management schemes, as well as the criteria to be met for a Capacity Review to be performed. In all instances the interests of individual patients should be paramount in the application of these approaches.

All contracts should be agreed by 28 February 2009 before the start of the contract year. There will be a clear and timely dispute resolution process to resolve the difficulties that may arise in some places. Parties who have not reached agreement by 28 February will enter mediation, and formal adjudication on any remaining disputes will begin at the end of March 2009.

The NHS Management Board has confirmed that any providers and PCTs which have not agreed a contract before 1 April 2009 will not be able to benefit from any of the contractual controls or protections that the Contract contains, until they have concluded an agreement on its terms. For providers this means that they will not be eligible to be paid regularly on the 15th day of each month. Rather, they will be paid in arrears for activity undertaken, on receipt of invoice. For PCTs it means that, for example, they will have no control over the volume of activity undertaken, and no performance management mechanisms to apply.

Coordinating commissioners will be required to work with providers to ensure they meet the national and locally agreed quality standards set out in Schedule 3, Part 4. This will contain existing national standards and commitments (eg A&E, MRSA and Clostridium Difficile (C.difficile)) and requirements of other national standards.

Coordinating commissioners will be expected to work with providers on the development and implementation of performance indicators reflecting local priorities. This element will be a matter for local negotiation and agreement.

Accurate and timely information is essential for effective commissioning and for the management of robust business processes. All providers are required to provide the information set out in Schedule 5, to the specified standards for quality and timeliness. This includes information required to monitor and assess payments relating to tariff flexibilities.

The Contract must support and encourage providers to innovate to improve services and the patient experience. It must also ensure that the benefits of innovation are shared as widely as possible across the NHS. An overall strategy on innovation is being developed through the NHS Next Stage Review. Pending this, the Contract sets out an interim approach to the assignment, licensing and dissemination of intellectual property which may arise during the term of the Contract. It will be necessary to review this interim approach through consultation with stakeholders once the strategy for innovation in the NHS is clear, and this aspect of the Contract will be subject to change through the normal variation procedures.

Delays in the transfer of care between Ambulance Services and Accident and Emergency Departments must be minimised wherever possible. The Contract provides for the monitoring and improvement of the handover of care between Ambulance Services and Accident and Emergency Departments. A requirement to monitor the handover process has been included in Clause 4 services.

Abortion services have a key role to play in providing advice and supply of contraception to reduce repeat abortions. In 2007, 198,500 abortions were performed on residents of England and Wales. Of these, 32 per cent (64,000) were repeat abortions. The rate of repeat abortion is impacting on delivery of the Teenage Conceptions PSA target: 10.5 per cent of abortions to under-19s are repeat abortions, and in some areas this proportion is as high as 20 per cent.

Providers and PCTs should agree the provision of advice, supply and fitting of the full range of methods of contraception for women undergoing abortion. Care pathways should also be in place to ensure that follow-up at general practice or community services is available, with the woman's consent. Work is under way to develop a national indicative price for providing this additional service element but, in the meantime,

commissioners and providers should agree pricing mechanisms that reflect local pathways and ensure seamless integration with existing contraception and sexual health services, including appropriate follow-up care.

Commissioners should put in place monitoring arrangements to ensure that women are being offered the full range of methods of contraception. Consideration is also being given to strengthening national monitoring arrangements. In particular, uptake of individual methods should be monitored to ensure women have a meaningful choice of contraception. The National Institute for Health and Clinical Excellence (NICE) has established that switching from the contraceptive pill to long-acting reversible contraceptive methods could have a significant impact in reducing unintended pregnancies, and that these methods are more cost-effective than the Pill after one year of use. Contraceptive implants and intrauterine devices are more cost-effective than the contraceptive injection. Commissioners and providers should also address workforce needs to ensure staff have the clinical and communication skills to provide high-quality advice and support and the technical skills to fit devices as appropriate.

Contracts will be an important delivery mechanism for High Quality Care for All and the implementation of local visions. Commissioners should ensure that their contracts reflect these visions and that they will drive the necessary improvements in quality, health and safety.

3. Structure of the Standard NHS Contract

The Contract has a three-part structure:

- elements which are mandatory
- elements which must be there, but the details of which are for agreement or completion by the contracting parties
- additional elements which can be added by local agreement

The mandatory elements are centrally set and should be considered standard NHS terms and conditions. They cannot be altered or removed, even by agreement of the contracting parties. If a PCT believes that any aspect of the mandatory elements prevents the Contract supporting a workable local agreement, this should be discussed with the appropriate SHA.

The second set of elements are contractual or legal requirements which are defined centrally, but which must be completed by agreement between the contracting parties. These elements must be fully completed as required to make the contract legally executable.

The third set of elements are to be locally defined – there is no national or legal requirement to include any such elements. Where contracting parties agree to include these they cannot undermine any of the mandatory or required elements. These elements could cover any issues, but typically might cover agreements on care pathways, treatment protocols, additional quality standards and local incentive schemes.

The Contract template and the Practical and Legal Guidance at Annex A and Annex B use colour-coding to clarify which elements are mandatory, which are required, but are for local agreement, and which are optional additions subject to local agreement.

4. Coordinated contracting: roles and responsibilities

The introduction of the interim version of the Contract in April 2007 was supported by a move to a new model of coordinated contracting. This will be maintained as the standard approach to contracting. It means that most providers will have a contract coordinated by a single PCT in each SHA region, and that other PCTs in the region whose patients use the provider will be Associate PCTs for that contract. SHAs have discretion to agree how these arrangements work locally and across SHA boundaries. These arrangements are significantly reducing the overall number of contracts and strengthening the commissioning relationship with providers, without confusing governance and accountability.

SHAs have agreed that, where a number of PCTs are each responsible for a significant proportion of a provider's activity, it may be appropriate in exceptional circumstances for a provider to hold contracts with more than one coordinating PCT within the provider's SHA area.

It is possible that some national tertiary centres may hold as many as ten contracts, with a coordinating PCT in each SHA area, and therefore be required to report separately on ten different sets of metrics. In such cases the principle of proportionality must apply in relation to the administrative burden placed on the provider. In any disputes about contract terms the agreement with the major local coordinating PCT should take precedence.

The roles and responsibilities of each of the key stakeholders are set out below.

Practice based commissioners

Practice based commissioners will not contract directly with providers, either individually or in consortia. Their main role is to advise PCTs of their commissioning priorities and agree plans for service redesign, which will shape PCT contracts.

Their responsibilities are:

- to agree care pathways, treatment protocols and demand management mechanisms with PCTs
- to manage demand for secondary care services in line with agreed protocols
- to commit resources through referrals
- to advise PCTs of any breaches of standards

Coordinating PCTs

The coordinating commissioner will have the following responsibilities:

- to negotiate and agree the Contract (including its Schedules and Annexes) with the provider to cover the requirements of its own patients and those of its Associate PCTs
- to ensure that providers receive Activity Plans to help plan their services, as well as acting as a focus for service redesign
- to agree the constitution of a consortium of Associate PCTs and ensure that all Associate PCTs sign a Consortium Agreement which provides for clear governance and accountability
- to coordinate the Activity Plans and payment schedules of Associate PCTs
- Associate PCTs are likely to include neighbouring PCTs and any others which commission a significant volume of activity from the provider. To simplify arrangements across SHA boundaries, coordinating PCTs will liaise with only one PCT in other SHA areas
- to meet the provider each month to review the performance of the agreement – in particular, progress with the Activity Plan – and to agree any actions required to remain within the Plan or to recover performance
- to agree the Prior Approval and Utilisation Management schemes with the provider
- to agree the appropriate range of local performance and quality standards to be included in the Contract
- to agree any amendments required to the Activity Plan
- to manage the Contract control mechanisms and advise Associate PCTs of any required actions or amendments
- to ensure that the provider treats equally all patients of equal clinical need, regardless of which PCT in the consortium is responsible for them (except where different care pathways are specified in the Contract for different PCTs)
- to manage the arrangements for information flows between the provider and Associate PCTs
- to pay the provider in accordance with the requirements of Clause 7

Associate PCTs

Each Associate PCT will develop its own Activity Plan and payment schedule.

The Associate PCT's main responsibilities will be to:

- agree and sign a Consortium Agreement with all other Associates
- participate in consortium governance as required
- identify any specific care pathway or standards requirements which it wishes to be accommodated by the provider
- pay the provider with the requirements of Clause 7
- participate in monitoring and review mechanisms, as agreed with the coordinating commissioner

It will not be appropriate to expect a service provider to manage its services in such a way as to have to accommodate an unlimited range of care pathway and quality and performance standards which might be specified by each Associate PCT. This would introduce a degree of complexity that would not be conducive to efficient and effective process management. However, it should normally be possible for providers to respond to a limited range of care pathway requirements, and in particular to accommodate differences in the diagnostic and discharge/aftercare stages of the pathway, and to support the Care Closer to Home policy.

No arbitrary limit will be placed on the number of care pathways providers are expected to support. Coordinating commissioners should work with their associate PCTs to achieve collaborative arrangements and minimise variation in the care pathways specified in the contract with each provider. Agreement on these arrangements should be achieved by PCTs through professional clinical leadership, and PCTs should take advice from their practices to inform their standards.

Strategic Health Authorities

SHAs have a key role in leading the development of commissioning arrangements within their region.

Their responsibilities are to:

- define the coordinated contracting arrangements for providers in their region
- mediate on disputes between providers and PCTs (with Monitor for FTs)
- adjudicate on disputes involving NHS Trusts
- resolve disagreements between PCTs
- ensure contracts are signed within the required timescale
- ensure contracts meet national and local requirements before PCT signature
- give permission for variations in contract duration
- enure consistency of local agreements across the SHA, including the application of contract thresholds and consequences

Specialised Services Commissioning Groups

The role of the Services Commissioning Group (SCG) is essentially the same as that of a coordinating commissioner, for the defined range of services it covers. Normally, SCGs will agree contracts directly with providers on behalf of their member PCTs. The Establishment Agreement of the SCG should operate as the equivalent of the Consortium Agreement, defining governance and accountability arrangements between member PCTs.

SCGs should take appropriate steps to ensure that their Establishment Agreements give them appropriate authority to enter into the Contract on behalf of their member PCTs. Legal advice may be required, as in some cases it may be necessary to amend existing Establishment Agreements.

Some SCGs, by agreement of their members and with SHA approval, may choose to include specialised services schedules within 'mainstream' contracts, rather than to hold separate contracts. In such circumstances, the SCG will be an associate commissioner, rather than a coordinating commissioner, and will need to enter into the Consortium Agreement. Again, SCGs should ensure that their Establishment Agreements allow them to act as associate commissioners in this way, where necessary taking steps to amend their Establishment Agreements.

In some areas PCTs have chosen to pool certain of their commissioning functions, such as contract management, with a variety of business service agencies, including outsourced arrangements. Where such arrangements exist, their role is to support PCTs in whatever functions are agreed. It must be clear that they act on behalf of PCTs, not instead of them. Under no circumstances can they be signatories to contracts.

5. Contract controls

Part of the purpose of the Contract is to enable the PCTs and providers to agree the rules and expectations of their agreements and to set out the methods for dealing with the consequences of failure.

On a day-to-day basis, the parties involved can and should resolve most issues which arise without resorting to the terms of the Contract, but the Contract does nevertheless set out the boundaries of what is expected in a clear and agreed form.

Performance management mechanisms are a necessary feature of the Contract. Used properly, these mechanisms provide protection for each party from the actions of the other.

The consequences of failure to comply with the terms of the Contract must be clear and apparent to all parties. The Contract sets out a clearly defined process for identifying and seeking to remedy performance problems and breaches of any contractual requirements. It is focused on providing sanctions for failing to remedy a performance failure, rather than penalising the initial failure.

For most indicators the most significant sanction for failing to remedy problems is for an Exception Report to be issued to the Board, and to regulators and the SHA.

In addition, the Contract provides for nationally mandated sanctions for the four indicators set out below:

- Breaches of the 18-week referral to treatment (RTT) target – a financial adjustment of 0.5 per cent of Contract income for every one per cent by which the 18-week target is breached
- inappropriate excess activity – non-payment for activity which has breached a Prior Approval Scheme, or has breached an Activity Management Plan, or has not been made subject to an Activity Management Plan because of a provider's omission to notify the coordinating commissioner
- breaches of the C.difficile reduction target – an annual financial adjustment to Contract income based on performance in reducing cases of C.difficile measured against the preceding year, with exemption for the best-performing providers as long as they maintain good performance
- failure to provide required information – temporary withholding of ten per cent of the monthly Contract value until the required information is provided

Providers and commissioners can, by agreement, introduce additional sanctions which they believe will support the operation of the Contract and underpin improvement.

The majority of the performance controls require warning and/or remedial action before any consequences are enacted. The intention is to expose performance failures and support improvement in a spirit of cooperation, not to sanction.

In addition to the sanctions which apply in the context of the control mechanisms, the Contract requires for incentive schemes to be developed and agreed locally, making a proportion of the provider's income conditional on quality and innovation. There remains the flexibility within the Contract to develop local incentive schemes, and these should be reflected in Schedule 18, Part 3.

During 2009-10, the Commissioning for Quality and Innovation Payment Framework is mandated for use in the Acute Services Contract. Separate guidance is being published for commissioners and providers.

Further information

To view the annexes mentioned in the Guidance, please visit:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100

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