

New Contract FAQs - updated March 2008

Section 1 General

Can the contract be used for contracting with Welsh and Scottish organisations?

The standard NHS contract is for agreements between PCTs and providers in England. Key aspects of the contract do not apply to NHS services in the other home countries. These include the tariff and the application of various standards and targets. The contract should not be used for agreements across national boundaries within the UK.

Will cross border arrangements be mandated by DH?

The standard NHS contract is for agreements between PCTs and providers in England. Key aspects of the contract do not apply to NHS services in the other home countries. These include the tariff and the application of various standards and targets. The contract should not be used for agreements across national boundaries within the UK.

Arrangements for contracts which cross SHA boundaries, or borders, will depend on the approach to co-ordinated commissioning agreed by the SHAs concerned. Any queries should be addressed to the SHA.

Can Local Authorities be party to the Consortium Contract?

This is not envisaged as part of this Contract. The Standard Contract is intended to govern the relationship between NHS Commissioners and Providers, and the Consortium Agreement is therefore designed to be entered into by Commissioners – Primary Care Trusts.

Does the contract only relate to services covered by PbR?

No. The contract is for the provision of all general and acute services. For non-PbR services local payment terms will be agreed.

What about other services, such as mental health and community services?

DH had intended to publish in January interim contracts that would be used by all PCTs in 2008/09. Stakeholders have now agreed that it will be more appropriate to continue the development work until March 2008 to ensure that the contracts are as robust as possible. A number of local health communities will be identified, who are willing to test and refine the interim contracts and to introduce them as early adopters. This approach will enable final versions of the contracts to be introduced across the NHS from April 2009.

There are a lot of schedules in the contract template that need local completion rather than having DH guidance. Will proformas be provided by DH?

In some of the schedules standard form letters and other proformas have been included, and there is a standard activity plan template. It is important, however, that the detail of the schedules is discussed and agreed based on local priorities. The contract guidance provides clarification on what should be included in each schedule, but no additional templates or forms will be issued.

For those Foundation Trusts who are not willing to move to the model contract, what incentives/benefits are there in the model contract to emphasise the need to move early?

Foundation Trusts are within their rights to continue with their existing contracts until they expire. PCTs should have given formal notice that existing contracts will move to the new standard format at the earliest opportunity. Where they have not yet done so, PCTs should clarify and act in accordance with the specific notice requirements of their contracts. FTs should, of course, be encouraged to adopt the standard contract as soon as possible. The benefits of changing are that:

- The standard contract provides greater clarity for both parties and greater protection in relation to the requirements to remedy performance problems.
- It is the only contractual framework which will be available in future, and it would benefit all parties to work within the new arrangements as soon as possible.
- The standard contract is better suited to the new co-ordinated commissioning arrangements, which will provide greater focus and clarity.

What needs to go into schedule 2 part 1. Guidance advises it is necessary to populate this part for the contract to work.

The intention within schedule 2 part 1 is to be clear about what services the provider will offer. Where detailed service specifications have been developed, as they have in many places, their inclusion here will give them contractual force. This schedule will become increasingly important as more service specifications are developed, and more services are subject to procurement processes.

Moreover, there may need to be a separate specification for each commissioner.

When DH looked at service specifications there were no uniform "best practices". However, service specifications would be in PCTs old SLAs or old FT contracts This should be used as a starting point and negotiate with the providers what will be entered here.

Based on experience a straight list of HRGs is not seen as useful.

**Please can you explain the following from clauses?
7.9 'statutory benefits'**

7.10 'statutory charges'

A statutory benefit - relates to the repayment of, say, travel costs to patients who are entitled to receive the benefit – DH guidance on travel costs are published

Statutory charges – includes those charges the NHS is entitled to make for services e.g. prescription charges

As host commissioner we are negotiating a standard 3 year contract with our main provider. One of our Associates has stated that they only wish to have a 1 year contract. Is it possible to have different contract periods under the same host agreement?

Associate commissioners agree to allow the coordinating commissioner to negotiate and execute the contract for them by signing the consortium agreements.

The contract is intended to be a three year contract and is negotiated as such. I would not suggest having a number of contract lengths within the main contract.

Clause 35 of the main contract deals with termination of the contract and as such notice would need to be served on the first date after service commencement to allow for the contract to cease after 1 year.

Clause 35.3 enables a partial termination to occur but the right to terminate can be exercised only by the Co-ordinating Commissioner, and the dissemination of that right to the Associate Commissioners is a matter for local agreement. Section 1 of Article IX of the pro forma Consortium Constitution gives each individual Associate the right to terminate the main contract with respect to the relevant services by instructing the Co-ordinating Commissioner to exercise that right on its behalf.

This should be a 3-year contract for the consortium. If the associate concerned is only a minor one it could be made clear to the provider that the proportion of the activity plan relating to the associate will only be for one year. The consortium agreement and the constitution between the PCTs would need to address the one-year relationship.

Clause 23, our local trust is concerned that this clause means that the Trust is required to share with the PCT the IP linked to drugs etc that they acquire by purchasing drugs etc - clearly this is not their IP to share and therefore it would be illegal to do so

2) 26.3 referring to the Provider's Insurance policies requires that the "Commissioners as loss payees are endorsed on each of them" As the Providers policies are for the Providers losses not the Commissioners the Commissioner is not a loss payee

3) Please could you provide us with a summary of all the amendments that have been made to the contract since it was first issued?

Clause 23 is concerned with ensuring that the Commissioners can use any "Provider IPR" where such use is necessary to enable the Commissioners to exercise their functions. The dispensing or other use of drugs by the Provider in delivering the Services is a matter for the Provider, and there does not appear to be any reason why the IPR in those drugs would need to be disseminated within the NHS. Accordingly, there would not appear to be any difficulty presented by any restriction on sub-licensing that may be contained in any license between the drug manufacturer and the Provider.

Moreover, there has been some attempt in the North West to agree standard formularies, but it is not expected that the IPR in any of those formularies would be part of the Provider IPR.

Clause 26.2 makes it plain that the scope of the insurance cover required of the Provider must extend to the Provider's "obligations and liabilities" under the services contract. Given that the Provider may be liable to a Commissioner under the indemnity in clause 26.1 for property damage, personal injury or other loss suffered by the Commissioner, it follows that the Commissioner has an interest in any insurance policy of the Provider that is aimed at underwriting that liability. These are the reasons behind the requirement in clause 26.3.

The contract published with the Operating Framework has not changed in a material way. Any minor change has been notified to SHAs and PCTs

When will the guidance on SUS be available through the DH (referred to p12 of FAQ published 5/2/8), especially re: reconciliation timescales?

Do you have any examples of prior approval processes or actual agreements that have been developed for inclusion in the contract?

The DH does not have any examples of prior approval schemes.

Do you have any model contract templates for primary care services commissioned through PBC?

The DH will be issuing a contract for use in 2009 for non acute (general) hospital services. PCTs should continue to use their current arrangements for the 2008/9 year and should ensure that any agreements signed this year expire on 31 March 2009.

APMS or other standard forms of primary care contracts would normally be used to commission primary care services through PBC.

Am I correct in assuming that we do not have to a) list or b) detail all our pathways within the contract?

Schedule 2 part 1 is the part of the contract where commissioned services are detailed. These schedules will form the basis of the review detailed in Clause 8. Putting detailed pathways into the contract, may not be advisable, as these may be revised frequently following reviews which will then need a contract variation.

Could you please give some examples of "documents relied-on"?

Paragraph schedule 14 from the guidance gives information on what is required. These may include consents from leaseholder allowing the service to be provided, copies of indemnities etc.

Is there a National list of Mandatory/ Protected services? Also, if there is, do they apply to all Trust, or just Foundation Trusts?

The mandated services are those services in the terms of authorisation of an FT.

I am an acute trust staff member - we do not appear to have a facility like this, so please could you help? In clauses 7.9 and 7.10 - what are statutory benefits and statutory charges?

A statutory benefit - relates to the repayment of, say, travel costs to patients who are entitled to receive the benefit – DH guidance on travel costs are published

Statutory charges – includes those charges the NHS is entitled to make for services e.g. prescription charges

Am I correct in my understanding that the term "Mandatory Services" only applies to Foundation Trusts?

The mandated services are those services in the terms of authorisation of an FT.

Does the contract allow for the recognition of income relating to spells that are incomplete (i.e. have started but not finished) at the end of the financial year?

There will need to be a local discussion to agree the handling of treatments that straddle the financial year. Some may choose to treat the patient admission as the charge point others (more common) may choose the patient discharge

Does the NHS contract need to be released in full if requested via a FOI request. Specific issue regarding 12 months Notice being given to delivery of services before consultation started / finished.

Further advice being sought. It would be difficult to justify not releasing the contract in response to an FOI request. Any such request would need to be assessed at the relevant time.

12 months notice of an intention to vary or terminate should not be taken as pre-empting a consultation. It just recognises that a consultation is planned which could lead to change.

Material Sub- Contractors.

There is a view that this only refers to the sub- contracting of clinical services, but we cannot see this stated anywhere in the contract or the guidance.

Assume that PCTs would also be interested eg in sub- contracting of cleaning services and other services that may affect patient care?

The parties can agree the list of sub contractors that they feel are material. Cleaning contractors, catering contractors, PTS and other services can be included as well as the clinical sub contractors if they choose to see them as material.

I have a query from our local Children's Trust who are concerned that the acute services contract has no formal reference to a duty of a provider to adhere to their statutory obligations to cooperate with local mechanisms to safeguard children. Their concern is summed up as:

This (the contract) leaves us falling short on the Working Together statutory guidance which states:

... that PCT Chief Executives have a responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole of the local health economy through the PCT's commissioning arrangements.

... that PCTs are expected to ensure that safeguarding and promoting the welfare of children are integral to clinical governance and audit arrangements. Service specifications drawn up by PCT commissioners should include clear service standards for safeguarding and promoting the welfare of children, consistent with LSCB procedures. By monitoring the service standards of NHS Foundation Trusts and contracted service providers, PCTs will assure themselves that service providers are meeting the required safeguarding standards.

Not only do we not have a specifically worded standard on safeguarding, we also do not have any specific way of monitoring compliance.

We had been trying to insert a performance indicator to schedule 3 part 4b but our local FT is resistant to any performance indicator that smacks to them of 'old style SHA performance management'.

My view has been that there is sufficient in the contract around clauses 16 and 19.1 for the PCT

A) To assure itself that it has discharged its duties in terms of ensuring providers are complying with relevant child protection legislation

B) To request information to demonstrate provider compliance if it had cause to do so

The contract requires all the parties to adhere to the "Law" see definitions in Schedule 1 and as such it was not the intention to specifically identify all aspects of the Law that the parties should follow.

The parties may think it appropriate to include specific references they wish as part of the services specifications for children's services. However it should be noted that the requirements in the schedules cannot supersede the requirements in the main contract clauses.

Do you know when the Department will be publishing more detailed guidance on PROMS (including templates and so forth), as indicated in the PROM guidance issued with the Operating Framework?

DH is currently working with its academic partners on the arrangements to make PROMs templates available to PCTs. Further details will be provided at the end of January. The PROMs guidance is available at : http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100

Is there a summary document produced of the main terms and conditions in the contract to help Trust ensure compliance and PCTs to monitor?

Legal guidance notes have been published in respect of the main services contract and the consortium contract.

As an associate PCT with a large contract value with our local trust, could you please advise as to how I ensure that our PCTs needs are included in the overarching contract held by the coordinating PCT. Do we need to specify our needs within the consortium constitution, or within the main document (schedule 14 other documentation relied up on)? Also what is the procedure to enable the PCT to be a joint signatory on the main document rather than signing the associate consortium document, or do we need to sign both.

All documentation and guidance can be found at

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

There is guidance around consortia agreements and how to deal with co-coordinating PCT where your PCT is an associate. If you hold a consortia agreement on the terms of the standard consortium contract the co-coordinating PCT, not the associate PCT, will be signatory to the main services contract. There will be separate services agreements for each consortium.

You will need to negotiate your requirements with the provider and coordinating PCT and these will be incorporated into the services contract. Your consortium constitution should govern how these negotiations will function and how, in particular, the views and opinions of the associate PCTs will be incorporated into the negotiations between the coordinating PCT and the provider. A consortium constitution pro forma has been published.

If you want to hold a separate contract you will need to negotiate separately with the provider. However it may be that the PCT with the provider in their patch may only allow a consortia agreement. In any case (and notwithstanding that the services contract is structured to enable each individual PCT to be a signatory to it), the PCTs will need to decide at a local level whether to execute the services contract via the agency route or the multiple signatories route.

Where can I obtain a copy of the 'Regulator's Registration of the provider' required under Conditions Precedent ?

The regulatory bodies will be dependant on the services that are being provided. These may include registration with those such as Healthcare Commission. In the future, and subject to the passage of legislation, the single regulator for all health services will be issuing the necessary documentation to all provider types including NHS Trusts which will fall into this 'conditions Precedents' requirements

Can you identify what you mean by 'Any Consents required for the provision of the Services by the Provider' under Conditions Precedent ?

Any consents may be in relation to types of services provided within certain settings such as leaseholder permissions etc

The term "Consent" is defined in Schedule 1. This is the meaning that it has in the context of Schedule 4 Part 1.

As the 2007/08 contract [gateway ref 7511] between [non FT] trusts and PCT's legally enforceable?

secondly, or in the alternative, in what circumstances would we use the SLA 'agreement for the provision of health services (revised Jan 2007)

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

The SLA published in January 2007 is not to be used for Acute services from 1 April 2008.

We currently commission a range of elective care services from small providers and I would like to know whether or not the new standard contract should be used from next year, or if we may maintain our existing SLA documentation. An example of such providers are:

**GPwSI in Dermatology (and others) - outpatient's only
Surgical service provided by a GPwSI - outpatient and day cases only
Independent company consisting of two Consultant Surgeons
GP company providing vasectomies**

2. All of these smaller providers offer services at below tariff prices. Will we fall foul of PbR, competition or contract rules if we continue to commission on this basis?

The following link will provide you with detailed information on the contract and who it is applicable to:

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

You can continue to commission these services through local SLAs and will therefore not affect tariff or contract rules

Acute services should be commissioned using the new standard contract. Existing FT contracts which have yet to expire or terminate will continue to use the contract that is in force. The FTs will transfer over to the new standard contract in due course. The acute contract is not to be used where GMS, APMS, SPMS contract are appropriate

Independent Sector providers will continue to use the existing contract arrangements (ECN/FCN) until the necessary legislation relating to CNST membership is enacted.

We are currently implementing a "willing Provider" supplier selection process. This results in a number of agreements with providers who cover the entire spectrum of provision:
NHS Trusts (including FT's)
The Private Sector
NFP / Charitable providers
GP's, dentists and opticians

The Agreements are for the provision of services for an agreed unit cost to a specification, there are no guarantees of volume or contract value. Ultimately spend on each of these services is likely to be small or moderate

I have a couple of questions arising out of this

- Is the new model contract for Acute Services applicable to this type of arrangement? Indeed is it appropriate as some of the services could be construed as "acute type" services**
- Some of the mandatory clauses cannot be applied, what lee way do we have?**
- Is there a 'lighter' document available or under development**
- How could we work to indicative activity targets where we are specifically excluding any commitment to purchase any value / volume of service.**

The contract is designed to be used for NHS Trusts and FTs (new or where contracts are due to expire) initially, with the independent sector coming on line later in 2008, as soon as the necessary legislation relating to CNST membership is enacted

However a PCT has a duty to provide value for money with the services it provides and issue appropriate contracts for the work agreed.

The Acute contract is not used where GMS, APMS or SPMS contracts are more appropriate

With regard to the acute contract the clauses that are mandatory and highlighted in red cannot be changed. Those clauses highlighted orange are required but can be locally negotiated.

It is not intended to produce a slimmer version of the acute contract and the contract as written does allow for a zero activity base – the provider will be treated as an NCA provider and paid on the production of an invoice

With the monthly monitoring timetable in the new contract, is there an expectation that Non Contracted Activity will also be analyzed, collated and invoiced monthly rather than quarterly? If so, will this be enforced with cut off dates?

Paragraph 7.4 of the standard NHS contract states :

On the 15th day of each month after the Service Commencement Date during the term of this Agreement each Commissioner shall pay to the Provider one twelfth of its individual Annual Contract Value identified in Annex 3 to Schedule 3 Part 1, and to facilitate the making of such payments the Provider shall supply to each Commissioner a monthly statement of account. In respect only of Services for which there is no Annual Contract Value, the Provider shall issue a monthly invoice to each Commissioner in respect of Services provided to that Commissioner which the Commissioner shall pay within 30 calendar days of receipt.

There will therefore be a monthly invoice raised for services where there is no annual contract value. The obligation of the PCT is to pay within 30 days of receipt of the invoice. It is not in a NCA providers interests to delay sending their invoice purely for business reasons

Schedule 3 of the contract deals with the activity reporting in more detail.

Would it be possible for you to send me a time line of work to be completed on the New NHS Contract?

It is up to the PCT and any co-coordinating PCTs to work together to ensure the contracts are signed by 28th February. The date the contract is signed becomes the effective date which will be different from the commencement date. However if Conditions Precedent are not satisfied by the "Longstop Date" (a date to be specified locally) the contract can be terminated.

Your SHA should be able to inform you of the date for submission to them of the activity profiles.

Full guidance and documents can be found on the DH website at :

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

Where do I find the acute contract for 2008/09?

You can find all the guidance and the standard contract at :

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

We have an acute trust who has indicated a wish to develop a service next year by recruitment of a consultant. It is unlikely this view will be supported by the PCT (following public health review) and as such activity plans will not reflect additional activity. The Trust has indicated they may go ahead with the development despite the PCT not supporting it and suggest that they will be able to market the service to GP's in order that referrals increase and as such the activity will be paid for under the contract as unmet demand. Could we receive some advice on what mechanisms within the contract could be used to either

place the financial risk for extra activity with the Trust or allow the PCT through the contract to prevent development of unwanted services (The trust is of the opinion that the present single handed consultant is unsustainable and this is the reason for wishing to recruit another).

We hope we will not have to use contractual controls , however it would be useful to know in advance of contract signing what may be used if the development takes place ?

The activity plan indicates the agreed level of activity that a commissioner will pay for and what the provider will deliver. Actions relating to any variation of activity within the overall specialties and in unplanned activity is clearly indicated in the contract and guidance under the performance mechanisms - the flow charts in the guidance may be of particular assistance.

I'm looking for a contract to use for contracting for services from the provider arm of our PCT, and with a prison who still provide healthcare services on our behalf.

Clearly the standard contract does intend to cover both of these scenarios but not at this stage - in the meantime is there interim documentation we can use.

The DH are producing contract documents during 2008 which will be reviewed by the service and the final version will be issued with the December 2008 Operating Framework for mandated use in 2009/2010. You will need to continue to use your current contract however it would be wise to ensure that your current contract expires on 31 March 2009 to allow you to transfer smoothly to the standard contracts that will be issued with the OF. When the new contract has been published, it will be announced via new@pcc weekly newsletter and via DH.

For schedule 3 part 1 Annex 2 - are we expected to profile GP referrals for all of our providers or just the one where we are the Host, and adopt the rates of the coordinating commissioner for the contracts where we are an Associate? Also, in Schedule 3 Part 1 Annex 3 - Is this full contract values or just the PbR elements?

As an Associate you should provide activity data for your Coordinating commissioner – as you are still entering a contract with the Provider even though you are not directly negotiating. It is important for all Associates to agree, where possible, conversion and other ratios for their providers. Specific needs in terms of a different ration will have to be reflected in the final contract documentation to allow a specific PCT to active their specific target.

Schedule 3 Part 1 annex 3 – is the full annual contract value for each commissioner – so includes PbR and non PbR elements

Please can you clarify when the new NHS Contract for mental health services will be issued, and from what date the DoH would anticipate us implementing it

DH had intended to publish in January interim contracts that would be used by all PCTs in 2008/09. Stakeholders have now agreed that it will be more appropriate to continue

the development work until March 2008 to ensure that the contracts are as robust as possible. A number of local health communities will be identified, who are willing to test and refine the interim contracts and to introduce them as early adopters. This approach will enable final versions of the contracts to be introduced across the NHS from April 2009.

Section 2 Aims and Principles

How 'Firm' must sign agreements before the start of the year?

Agreements between PCTs and providers must be seen as 'genuine' agreements, and a signature to the contract signifies acceptance by both parties to the terms and details of the contract. It will not be acceptable for organisations to sign heads of agreement and seek to resolve the detail at a later date. Specifically, agreements will ensure that PCTs pay providers for all activity duly delivered according to the PbR Code of Conduct and in line with the parameters set out in the contract.

If you have not signed the contract as an Associate but you pay the Provider directly, have you entered into a contract with that Provider?

If a PCT has not entered into the Contract as an Associate but refers a patient to the Provider a basic agreement for the provision of a service by the Provider, and for its payment by the PCT, will arise. However, this will not be on the terms of the Standard Contract and neither the PCT nor the Provider will be able to benefit from the terms of the Standard Contract in relation to the referral. For the PCT, this means for example that none of the contractual protections that the Contract contains will necessarily apply, and likewise for the Provider. The PCT will need to make the appropriate payment to the Provider within 30 days of receipt of the Provider's invoice.

Contracts with Providers should be agreed by 28 February, before the start of the contract year, so it is not anticipated that any PCT will operate on the basis of the "basic agreement" described above.

For those Foundation Trusts who are not willing to move to the model contract, what incentives/benefits are there in the model contract to emphasise the need to move early?

Foundation Trusts are within their rights to continue with their existing contracts until they expire. PCTs should have given formal notice that existing contracts will move to the new standard format at the earliest opportunity. Where they have not yet done so, PCTs should clarify and act in accordance with the specific notice requirements of their contracts. FTs should, of course, be encouraged to adopt the standard contract as soon as possible. The benefits of changing are that:

- The standard contract provides greater clarity for both parties and greater protection in relation to the requirements to remedy performance problems.
- It is the only contractual framework which will be available in future, and it would benefit all parties to work within the new arrangements as soon as possible.
- The standard contract is better suited to the new co-ordinated commissioning arrangements, which will provide greater focus and clarity.

Could explain, please, the difference between a discharge protocol and a discharge policy, within the meaning given to "Discharge Protocol" in the contract. Are the terms interchangeable?

The NHS Contract refers to and gives the definition of a Discharge Protocol throughout the document. A policy is an overarching document that gives a strategic view and a protocol gives more details on what is actually required to comply with the policy.

Section 3. Structure of the Contract (Mandated v Local)

Schedule 2 Part 3 contains a Major Incident Plan and suggests the inclusion of an Emergency Response Plan beneath.

I'm not being coy but is there a difference?

The way the schedule is drafted it suggests these are two different plans but I suspect that the title (Part 3: Major Incident Plan and Emergency Response Plan) is misleading.

Your section Major Incident Plan contains the terms should a Major Incident (or emergency incident) occur. The second section entitled Emergency Response Plan should contain the requirements that we as a PCT specify.

In the PCT here we have an obligation, as with all NHS organisations, to comply with the Civil Contingencies Act to be capable of coping with eg. bombing, flooding etc. For this we have business continuity plans and expect our Providers to address the same obligations.

Schedule 2 part 3 sets out the contractual obligations during a major incident with the provider's emergency response plan to be inserted below, which will be subject to local determination and agreements.

I have copied the guidance which shows that the major incident plan is mandatory but the emergency plan, whilst mandatory is subject to local agreement

I think the questioner is right here; in most cases there will be only one plan. The two aspects of it are emergency response and business continuity.

Given that both plans are addressed within the same part of the same Schedule (which avoids the problem of one Part of a Schedule being left blank if only one plan is used), the Schedule can include whatever the parties think is appropriate, whether it be one Aggregate Plan one or two separate plans.

We've been going through the new contract in detail. Our query relates to Schedule 4, Part III - do we specifically need details on transitional arrangements given that the contract has to be signed off by 28th Feb? Any guidance/clarification would be most welcome.

This section of the contract is for local determination. Section 2.4 of the Standard Contract sets out the type of issues that may need to be included and effectively this provides an additional period after signing for further discussions to take place. Any timescales agreed beyond the contract start date need to be recorded.

All contracts are due for formal sign off by the parties on or before 28 February 2008 to allow system changes to be completed by the parties during March ready for service commencement on 1 April

As the questioner implies, the transition period is of less relevance in the circumstance where the services are already running and it is the contract which is changing, than if

the contract were being agreed from scratch for the introduction of new services (eg with an IS provider). In such cases, it may be that the matters required to be in place by the conditions precedent are in place already, with the result that the Service Commencement Date and the Effective Date are, for all practical purposes, the same. This schedule will become more useful once IS providers adopt the new contract.

The PCT has decided that in light of recent national issues with identifiable personal information that commissioned service contracts with providers should include a statement on information governance and data flows etc.

I wonder if there is a standard clause/statement given that the focus on IG is NHS wide.

There is not a standard clause on information governance and the DH is not producing one. However, this is clearly a topical issue of concern and the DH would encourage agreement on local clauses to be included.

NHS East of England raised a similar question. Their CIO has drafted a clause on information governance for inclusion in their local contracts. The PCT may wish to ask the SHA to discuss with NHS EoE (Andy Vowles) whether they wish to share their proposed approach.

Can you please give guidance on what the Emergency Response Plan might contain, and how it differs from a Business Continuity Plan ?

The definitions are as follows:

“Emergency Response Plan”

means the plan agreed by the Parties to deal with any emergency situation that may put additional strain on the capacity of the NHS to respond and set out in Schedule 2 Part 3;

“Business Continuity Plan”

means the Provider’s plan referred to in Schedule 4 Part 1 and clause 4.10 relating to continuity of all of the Services, as agreed with the Coordinating Commissioner and as may be amended from time to time, which for the avoidance of doubt shall include a plan in relation to the ongoing provision of the Services Environment and the Equipment or equivalent replacements thereof;

A business continuity plan is dealing with day to day running of the provider’s business whereas the emergency response plan will be dealing with emergency situations, such as pandemics, major traffic incidents etc. I hope this makes things clearer.

It states that penalties should not be imposed for breaking a clause but for not acting to remedy the problem. If in 2007/08 we have as a PCT been advising trusts on where they are 'failing' does this mean we can impose penalties from the start on such parts of the contract? For example if we have been highlighting to the trust all year that they are not keeping to agreed follow up ratios on certain procedures, and they continue to over perform on this, do they get another warning in April 2008 before we can penalize them?

The PCTs requirement for follow up ratios should be included under Schedule 3 part 4a under services provided requiring rectification. As you still have two months within the existing contract it would be reasonable that the remedy should be clarified now and confirmed actions set in motion. Then included from month 1 of the new contract as a penalty if not rectified. Alternatively, a longer lead-in time could be agreed, and clear milestones could be included within the Transition Arrangements (Schedule 4, Part 3) such that the problem is required to be rectified over a slightly longer period but, in any case, before service commencement.

Section 4. Co-ordinated commissioning and contract management

What is expected of co-ordinating PCTs?

The principles of how the co-ordinating PCT model might work are set out by DH, as follows. Within these principles SHAs have the flexibility to adapt the model to meet local needs and arrangements. SHAs will consider with commissioners and providers whether PCTs outside of the provider's own SHA should contract through the co-ordinating PCT in their own SHA or the co-ordinating PCT in the provider's SHA.

It is possible that some national tertiary centres may hold as many as 10 contracts, with co-ordinating commissioners in each SHA area, and therefore be required to report separately on 10 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 co-ordinating PCT should take precedence.

The co-ordinating PCT (or PCTs) will have the following responsibilities:

- To negotiate and agree the contract (including its schedules) with the service provider to cover the requirements of its own patients and those of 'associate' PCTs
- To co-ordinate and aggregate the activity plans and profiles and payment schedules of associate PCTs, to include within the contract a single activity plan. (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 co-ordinating PCTs will liaise with only one PCT in other SHA areas)
- To meet the provider each month to review progress with the activity plan and agree any actions required to remain within plan or to recover performance
- To agree any amendments required to the activity plan to respond to significant changes in the volume or flow of activity arising from patients' choices or appropriate changes to conversion rates
- To advise associate PCTs of any agreed actions or amendments
- To ensure that the provider treats equally all patients of equal clinical need, regardless of which PCT is responsible for them
- To identify any financial adjustments which might be applicable as a result of over-activity, breaches of the 18-week milestone or breaches of prior approval requirements
- To apportion the benefit of any financial adjustments between associate PCTs based on the proportion of contract value (not on the basis of the PCT responsible for the patients involved in individual breaches)

Can Local Authorities be party to the Consortium Contract?

This is not envisaged as part of this Contract. The Standard Contract is intended to govern the relationship between NHS Commissioners and Providers, and the Consortium Agreement is therefore designed to be entered into by Commissioners – Primary Care Trusts.

Does signing the Consortium Contract as an Associate transfer undertakings to the Co-ordinator (as with section 75 agreements)?

The Consortium Agreement does not transfer any undertaking. Each Associate has a contract with the Provider, the Co-ordinating Commissioner just co-ordinates and enters into the contract on their behalf. It confirms joint purchasing arrangements and the authority of the Co-ordinating Commissioner.

If you have not signed the contract as an Associate but you pay the Provider directly, have you entered into a contract with that Provider?

If a PCT has not entered into the Contract as an Associate but refers a patient to the Provider a basic agreement for the provision of a service by the Provider, and for its payment by the PCT, will arise. However, this will not be on the terms of the Standard Contract and neither the PCT nor the Provider will be able to benefit from the terms of the Standard Contract in relation to the referral. For the PCT, this means for example that none of the contractual protections that the Contract contains will necessarily apply, and likewise for the Provider. The PCT will need to make the appropriate payment to the Provider within 30 days of receipt of the Provider's invoice.

Contracts with Providers should be agreed by 28 February, before the start of the contract year, so it is not anticipated that any PCT will operate on the basis of the "basic agreement" described above.

If you don't sign the contract as an Associate, do you indemnify yourself against the actions of the Co-ordinator?

If a PCT does not accept the obligations of the Standard Contract, it will normally have no place in the consortium of Commissioners that appoints the Co-ordinating Commissioner, and which authorises the Co-ordinating Commissioner (in the Consortium Agreement) to act on their behalf. In these circumstances, the PCT will have no relationship with the Co-ordinating Commissioner or with the consortium, and will have no need for any indemnity.

By contrast, if a PCT is a member of the consortium then this area of liability will be clarified to the extent that an indemnity will apply to protect the PCT from any loss or damage it suffers as a result of negligence or breach of contract (whether in respect of the Consortium Agreement, the Standard Contract or the Constitution of the Consortium) on the part of either the Co-ordinating Commissioner or an Associate Commissioner.

How can the Consortium contract be a legal 'contract' if the signatories are PCTs, (and all act for the Secretary of State)?

The Consortium Agreement is not a legally binding contract because it is between NHS parties. It is not intended to be a legally enforceable contract, but rather to be a mechanism to co-ordinate and streamline the commissioning process

Will cross border arrangements be mandated by DH?

The standard NHS contract is for agreements between PCTs and providers in England. Key aspects of the contract do not apply to NHS services in the other home countries. These include the tariff and the application of various standards and targets. The contract should not be used for agreements across national boundaries within the UK.

Arrangements for contracts which cross SHA boundaries, or borders, will depend on the approach to co-ordinated commissioning agreed by the SHAs concerned. Any queries should be addressed to the SHA.

What are the benefits of the co-ordinating commissioner model? Will it be more bureaucratic?

Currently some providers, especially tertiary centres, may hold dozens of separate contracts with PCTs whose patients use their services. This is a complex, expensive and time-consuming arrangement.

The co-ordinating commissioner arrangements will simplify this so that providers will normally only have one, and certainly no more than a handful of contracts. This will allow for greater standardisation and a simpler set of quality and performance requirements for providers.

Under these arrangements performance management of providers will be clearer and less fragmented.

Co-ordinating PCTs will have the additional responsibility to identify associate PCTs, and to aggregate their activity plans. However, this additional burden will be off-set to some extent by the requirement for them to relate directly to fewer providers. They will have fewer contracts to negotiate and performance-manage.

What does it mean for those PCTs who will not have a co-ordinating commissioner responsibility?

Some PCTs may not be identified as co-ordinating commissioners for acute service providers (eg if there is no acute provider within their geographical boundary and they are not responsible for a significant proportion of a single provider's business).

This does not mean such PCTs will not have a commissioning role. They will be able to agree through their consortium arrangements with co-ordinating PCTs how active a role they wish to play in contract negotiation and performance management.

Of course these activities represent only a small part of the wider commissioning process. All PCTs will continue to be individually responsible to work with their practice based commissioners on all other elements of the commissioning cycle including:

- Needs assessment

- Reviewing service provision
- Deciding priorities
- Designing new service models
- Shaping the structure of supply
- Managing demand and ensuring appropriate access to care
- Managing performance of primary care and non-acute services
- Measuring and reporting on patients' experience and satisfaction.

All PCTs will continue to have joint commissioning responsibilities with local authorities and other partners, and will maintain their existing contractual relationships with mental health and community services providers and primary care contractors.

Will co-ordinating PCTs be expected to involve practice-based commissioners from other PCT areas in contract negotiations with secondary care providers?

Co-ordinating PCTs are expected to engage their practice based commissioners in contract negotiations and agreement with secondary care providers.

Co-ordinating PCTs will not be expected to engage widely with the practice based commissioners of associate PCTs. Such practices will engage with their own PCT, which will incorporate their requirements into the activity plans which they provide to the co-ordinating PCT.

What are the implications of the Framework for procuring External Support for Commissioners that will allow PCTs to buy in commissioning support services from private sector companies?

PCTs may wish to use the services of a private company in areas of commissioning including contract negotiations. These arrangements should not be affected by the co-ordinating PCT requirements. The PCT continues to be the responsible and accountable body for commissioning, but may choose to engage a private company to act on its behalf.

What does this mean for specialised services commissioning groups?

The commissioning arrangements for specialised services commissioning groups (SCGs) were set out in Health Reform in England, update and commissioning framework (July 2006). SCGs have been established in each SHA area, within a host PCT, to commission a defined list of specialised services.

These arrangements will generally remain outside the responsibilities of co-ordinating PCTs who will agree contracts with providers for general and acute services.

SCGs will use the new NHS Contract as the basis for their agreements.

How are the performance management arrangements for nationally-procured Independent Sector providers affected?

Until legislation is changed to enable Independent Sector membership of CNST the Independent Sector providers are required to contract via ECN and FCN arrangements.

The DH Commercial Directorate will continue to be responsible for the performance management of nationally-procured contracts.

What does it mean for commissioning business service agencies and procurement hubs?

A number of PCTs have pooled some of their commissioning functions into local or regional commissioning business service agencies or procurement hubs. These arrangements will work to support the co-ordinated commissioning arrangements in whatever ways are agreed by the member PCTs. Each individual PCT continues to be the responsible and accountable body for commissioning, but may choose to operate through such shared service arrangements.

An issue has been raised to state that charges could be raised up to 6 years following activity this would appear to be contradicted on page 18 Information Requirements, paragraph 29.6. This seems to suggest that corrections or amendments can only be made up to the reconciliation date. Does this section mean, that once the reconciliation date has arrived, the data is, in old terms, frozen, and the finances for that period frozen also?

The question appears to confuse the contract law rules regarding the limitation periods with the provisions in the contract dealing with payments and reconciliation accounts

(i) Under contract law, an action in respect of breach of contract must be commenced within the relevant (limitation) period specified in the Limitation Act 1980. For simple contracts (as opposed to deeds), this means within 6 years from the date of the breach.

(ii) The payment provisions in clause 7 and their relationship to the information provisions in clause 29 mean that all data in respect of a particular month is meant to be finalised as at the relevant Reconciliation Point, albeit that the associated reconciliation payment is not triggered until the reconciliation account is agreed by the provider (clause 7.7). The period in which such agreement should be indicated is not specified, and it would be within the ability of either party to refer any ongoing disagreement to the dispute resolution mechanism.

Clause 29.6 simply allows the provider, at any time between the initial submission of monthly data via SUS (under clause 29.3) and the Reconciliation Point, to make any corrections or amendments to the initial data submitted via SUS.

It should also be noted that commissioners can endeavour to control the quantity (in percentage terms) of SUS data that is corrected during the period mentioned above by including an appropriate performance indicator in Schedule 3, Part 4B.

Service provided requiring rectification" is one of the standards proposed for acute hospitals. Could you please explain what does it mean for commissioners and how to set threshold for this standard?

Schedule 3 part 4 of the standard contract deals with locally agreed standards. These should include MRSA, C Diff, Standards for Better Health etc as well as any areas PCTs

as local commissioners wish to develop. These will be for local determination and negotiation based on services that are currently being provided and what the PCT would like delivered. Areas that have a shortfall will need to be looked at and steps to rectify should be identified within the contract.

2.13 Co-ordinating 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 and MRSA, and Clostridium Difficile), and the requirements of *Standards for Better Health*.

2.14 Co-ordinating 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.

All guidance and documents can be found at:

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

Clause 18.3 gives a profile from 72 to 24 hours for Discharge Summary provision over the next 3 years. Hampshire PCT are already down to 48 hours for this activity and the mandated text is also in conflict with our Commissioning Intentions in Schedule 11 Part 2.

How can we avoid allowing the Providers to reduce their performance?

Can we state the current performance of 48 hours as a minimum and set stretch targets in Schedule 3 Part 4b?

Whilst locally agreed timescales could be built into Part 4B of Schedule 3, it must be remembered that the mandatory sections of the contract (which include clause 18) prevail over any contrary provisions set out in the locally-agreed sections (such as Schedule 3).

The locally-agreed timescale could nevertheless operate as a practical incentive during Year 1. The contract provides for the 48-hour standard to apply during Year 2 in any event.

Section 5. Contract controls

Healthcare Associated infection – how do you tie colleagues that are not in the NHS (Social Care, Private Nursing Homes etc) into strategic priorities?

The contract controls are clear about how parties to the contract should work together to remedy performance problems or failures (the flow charts support this). PCTs will also need to work with partners in primary care and private providers to build in the Operating Framework priorities into their agreements or performance regimes.

Hospital Associated infection – If the provider hadn't implemented an improvement plan, do financial sanctions apply?

For the c.diff target the best performing trusts will be exempt from financial sanctions based on the performance in 2007/8.

For those not exempt, financial sanctions for failure to achieve the c.diff target can only be applied after the year-end once the annual reconciliation has taken place. The sanction will be available to the commissioners on this target, even if an improvement plan has been implemented, if the required improvement remains unachieved.

Contract controls are framed so that at an early point in the year any variation from trajectory can be identified and necessary remedial actions can be agreed. Commissioners will be expected to take account of what efforts to improve have been made, in deciding whether to apply sanctions.

Section 6. Managing activity and referrals

Where should I record details of Prior Approval schemes?

There is no specific place to insert details of agreed Prior Approval schemes in the contract. They could be inserted in "documents to be relied on" but if they are, a formal process would be needed if they are subsequently changed. DH suggests that any Prior Approval Schemes, that are agreed, remain outside the contract so that they can be added to and edited without the need to vary the contract.

Any new or changed Prior Approval schemes should be signed by both parties when agreed and recorded in the minutes of the Monthly Contract Review Meeting. This would then make them difficult to dispute.

These contracts include prior approval schemes. Shouldn't treatment decisions be made by clinicians, not managers?

Prior approval schemes are not designed to undermine clinical judgement. The schemes act as a mechanism for commissioners to be assured that patients receive treatments which are clinically effective and part of an agreed pathway. It is expected Group Prior Approval will form the majority of Prior Approval schemes. For the majority of treatments, commissioners and providers will agree in advance how to manage patients and pathways. This means, providing the patients are treated to the agreed protocols, approval to proceed is automatic. Such protocols must have the agreement and support of clinicians. Prior approval must never delay any clinically necessary treatment and the interests of individual patients will remain paramount. Retrospective approval for individual patients will be permitted where the provider deems there to be an urgent clinical need or risk to the patient.

The approach used by Birmingham East & North PCT for group PA is that clinicians in the PCT and trust agreed, for each speciality, the changes to the pathway – e.g. PA for tonsillectomies. The PA directive specifies the graduation process for patients. If the patient has received treatment in line with the pathway, the intervention has not worked and the patient continues to have significant health problems, then the consultant will be able to undertake the procedure in line with the PA directive without recourse to the PCT.

It is a local decision whether commissioners may want to consider including a prescribing scheme under PA. Secondary care clinicians could recommend the class of drug for a patient, and the actual drug would be determined by the patient's GP – for example recommending statins rather than a specific statin. Recently published 'Better Care, better value' indicators showed that if every PCT prescribed pravastatin and simvastatin (generic versions) in 69% of cases then over £84.7m could be saved in a year.

What about local variations in Prior Approval schemes?

To reduce bureaucracy, where providers are taking patients from a number of PCTs and there is a lead commissioner arrangement in place, the provider would be expected to follow the co-ordinating PCT's Prior Approval scheme. It will be the responsibility of that PCT to seek agreement on this Prior Approval scheme from its associate PCTs. However, there may be certain circumstances where commissioners will wish to adopt

different approaches to Prior Approval with the same Trust. A balance must be struck in enabling commissioners to deliver their plans while avoiding unreasonable operational demands on Trusts. Some variation will be acceptable but the onus will be on the coordinating commissioner, working with the Trust, to hold the ring in such discussions.

Who Will Pay for Utilisation management Schemes?

Providers are encouraged to embed UR type processes as a standard within routine clinical management. Should PCTs request for UR, which the provider does not deem necessary, then it is for the PCT to fund the cost of the review, and for providers to collaborate openly.

Section 7. Activity planning and monitoring

What happens if the provider declines to agree the schedules as they represent more activity than the provider believes that it can realistically provide?

The general principle is that the quid pro quo for PCTs paying at tariff for all activity is the expectation that providers will flex their capacity to meet demand – since increased activity is at full price it should normally be to the advantage of the provider to do so.

However it is recognised that there may be occasions where, because of some specific event, such as another provider closing capacity, the aggregated demand for activity from all PCTs is at an impractical level for the provider to achieve within the year. In such circumstances the Co-ordinating PCT, with the support of their SHA, should seek through discussion to find an equitable solution; however, failing resolution, the problem should be escalated and the pre-contract dispute resolution processes will apply.

Unbundling tariff: how are different requirements of participating PCTs accommodated by the contract?

PCTs within a co-ordinated contract may well have requirements for different pathways and different unbundling arrangements. Whilst such unbundling may not affect the levels of activity in the schedules, the arrangements will need to be defined in the pathway schedule and payment arrangements defined. Co-ordinating PCTs need to ensure that any such arrangements are defined.

Administration of the payment adjustments resulting from such arrangements will be for each individual PCT.

Are there any TUPE considerations of revising pathways in-year?

As activity flows and demand change, NHS organisations will continue to plan services accordingly. As care increasingly moves to settings outside hospitals organisations will want to be sure that services and resources are in the right place. This is already the case and the normal processes for managing change will be unaffected by the contract.

What is the minimum level of expected activity that will require a PCT to develop an activity plan for a particular provider? What are the implications for NCA arrangements?

Co-ordinating PCTs will need to aggregate activity plans from all PCTs which choose to be an associate. The minimum expected level of activity above which a PCT would be required to complete an activity plan and become an associate will be agreed locally and approved by SHAs. Below the locally-agreed minimum PCTs may choose whether to complete an activity plan or to deal with the activity through choice arrangements for elective care. The existing Non-Contract Activity arrangements for urgent care will continue to apply to services not covered by an activity plan.

The contract states that data sets are required within five working days in providing SUS data – how was this timeframe determined and how can providers achieve that?

The new requirements on information flows through SUS are not mandatory until April 2009. The timescales for the various elements of information flows have been determined through discussion between DH, the NHS and stakeholder groups. The new requirements will be very challenging for all parties, but particularly for providers, and it is recognised that further clarity is required on what is expected, particularly in relation to reconciliation timescales. This will be provided shortly by DH.

The Audit Commission have suggested that data submitted in less than 10 days will jeopardise quality?

PCTs and providers need to agree the joint way forward. The key issue is to see improvements and agree the level of quality and accurately versus time targets

Section 8. 18 Weeks

Will capacity reviews be routine?

Capacity reviews are only to be triggered in extreme circumstances, during the year, including material and unexpected changes in key assumptions. . The outcome of the capacity review may trigger a limitation or suspension of the financial adjustments, however providers will not be allowed to refuse referrals on capacity grounds, as this is not consistent with Choice.

Section 9. Quality and outcomes

Section 10. Dispute resolution