NHS England

# Draft NHS Standard Contract 2022/23: A consultation

## Proposed changes to the NHS Standard Contract for 2022/23


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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Table of Contents


**1 Introduction** ..... 3
**2 Context for 2022/23** ..... 3
**3 Pre-consultation engagement** ..... 4
**4 Period covered by the Contract** ..... 5
**5 Proposed changes to Contract content** ..... 5
**6 Online presentation of the Contract** ..... 15
**7 The shorter-form Contract** ..... 17
**8 Low-volume flows of activity** ..... 18
**9 Consultation responses** ..... 18

# 1 Introduction

1.1 This consultation asks for views from stakeholders on changes which NHS England proposes to make to the NHS Standard Contract for 2022/23.

1.2 The NHS Standard Contract is published by NHS England for use by NHS commissioners to contract for all healthcare services other than primary care services. We are now consulting on changes for 2022/23 to both versions of the Contract – the full-length version, which is used to commission the bulk of such services by value, and the shorter-form version, which can be used in defined circumstances for certain less complex and typically lower cost services. The updated Contracts are available on the NHS Standard Contract 2022/23 webpage.

1.3 This consultation document describes the main, material changes we are proposing to make to both versions of the Contract. We welcome comments from stakeholders on our proposals, along with any other suggestions for improvement. Comments on the draft Contracts can be submitted via an online feedback form.

1.4 **The deadline for receipt of responses is Friday 28 January 2022. We will publish the final versions of the generic Contract (both full-length and shorter-form) as soon after that as possible.**

# 2 Context for 2022/23

2.1 The Health and Care Bill is currently progressing through Parliament and is scheduled to start taking effect from 1 July 2022. When enacted, the Bill will bring significant changes to the way in which the NHS operates, but some aspects will remain familiar. Once established and operational, Integrated Care Boards (ICBs) will be commissioners, "arranging" services in accordance with their statutory duties and paying different (NHS and non-NHS) providers to deliver them, much as CCGs do now. So there will be contractual relationships between ICBs and providers, and it will be necessary for written, signed contracts to be in place setting out the terms and conditions of those contractual relationships.

2.2 Equally, we believe that it will remain necessary and appropriate for NHS England to mandate core terms and conditions for such contracts at national level, and our expectation is that updated regulations will allow for this, as the Standing Rules regulations do currently.

- Mandatory national terms allow us to set, at a high level, consistent national standards of care (to be followed by all providers of NHS-funded services) and to promote local implementation of key national policy priorities.

- They offer significant economies of scale (avoiding ICBs having to pay lawyers to draft contract terms locally).

- They provide one set of contractual rules and processes, easily understood by all – and a level playing field for NHS and non-NHS providers.

2.3 It is in this context that we will publish the NHS Standard Contract for 2022/23. Over time, we envisage that it will evolve, following the direction of travel set out in the Bill and in our national guidance on the development of Integrated Care Systems, in a way which

- reduces the burden and transactional bureaucracy associated with the contracting process; and

- promotes integration of patient services across different local providers and collaboration more generally between ICBs and local providers.

## 3 Pre-consultation engagement

3.1 During summer and autumn 2021, we ran an informal engagement process, testing the views of stakeholders about how the Contract should evolve for 2022/23 and beyond. Over 170 stakeholders completed a detailed online survey, and feedback on contractual issues was also received from online workshops dealing with the future development of the National Tariff Payment System.

3.2 We have taken three key messages from the engagement feedback.

- Overall, stakeholders support an approach which maximises continuity for 2022/23, rather than wishing to see immediate radical changes to the content of the Contract. The 2022/23 planning and contracting round will be challenging; CCGs will be in the process of organisational change as ICBs are established, and Trusts will have had two years, under the pandemic, without signed contracts. In this context, a relatively familiar, well-understood Contract for 2022/23 will mean “one less thing to worry about”.

- The Contract sets out processes through which the commissioner / provider relationship is managed and the commissioner holds the provider to account – covering, for instance, performance management, audit, information and reporting flows, activity management, payment, subcontracting, variations, dispute resolution and suspension / termination. Stakeholders recognise that it may be possible to make these processes less detailed and lighter-touch in time, as ICBs mature, but support the approach of
  - retaining the existing processes largely unchanged for 2022/23, but undertaking a thorough review of them for 2023/24; and

- emphasising in guidance that – where system working relationships within an ICB are mature – it should only rarely be necessary for local parties to rely on these processes in practice. (In other words, the formal contract management processes in the Contract provide a backstop for when things go wrong, but they don't have to be used when things are going well.)

- Otherwise, simplification of aspects of the Contract for 2022/23 – fewer requirements for local detail to be completed, the nationally-set General Conditions (GCs) and Service Conditions (SCs) to be incorporated by reference to the published online versions, rather than exchanged in paper form locally – would be welcome.

## 4 Period covered by the Contract

4.1 The Contract is intended to set national terms and conditions applicable for the 2022/223 financial year. If issues arise in-year which require any amendment to the Contract, NHS England will consult on changes as necessary.

## 5 Proposed changes to Contract content

5.1 We describe below the main, material changes we propose to make to the content of the full-length version of the Contract for 2022/23.

**Adapting the Contract to reflect the Health and Care Bill**

5.2 Publishing the Contract at this point – when the Parliamentary process to progress the Health and Care Bill is well advanced, but when the Bill has not yet received Royal Assent – poses some challenges. The Bill provides for the abolition of some organisations and concepts to which the Contract refers, for instance, and establishes new ones. This is true in respect of

- the abolition of Clinical Commissioning Groups (CCGs) and the establishment of ICBs;
- the abolition of Monitor and of the NHS Trust Development Authority, with their relevant functions being assumed by NHE England;
- the abolition of the Healthcare Safety Investigation Branch and the establishment of the Health Services Safety Investigations Body;
- the abolition of Local Education and Training Boards;
- the replacement of the National Tariff Payment System by the NHS Payment Scheme;
- the replacement of the current rules governing procurement of NHS-funded healthcare services (the Procurement, Patient Choice and Competition Regulations and the Public Contracts Regulations) by a new NHS Provider Selection Regime; and

- changes to the scope of the NHS Provider Licence, meaning that the Contract concept of "Essential Services", currently applicable only to NHS Trusts, will no longer be needed, as NHS Trusts will come within scope of the Commissioner Requested Services regime within the Licence provisions.

5.3 Clearly, NHS England must not, in publishing the draft Contract, seek to pre-empt the will of Parliament by making assumptions about whether, to what extent and when the Bill will be enacted and/or the relevant provisions will come into effect. We have therefore sought, at this stage, to "future-proof" the wording of the draft Contract, so that its provisions can operate effectively whatever Parliament decides about enactment of the Bill and relevant provisions coming into effect. In practice, we have done this by introducing two new terms:

- **the 2022 Act**, defined as "the Health and Care Bill (Bill 140) once it has received royal assent"; and

- **the Commencement Date**, defined as **"**the date that a section or a paragraph of a schedule of the 2022 Act comes into force".

5.4 We have then

- retained the current references to the existing organisations and concepts listed above – and also included references to the new organisations and concepts proposed under the Bill (note that we use the name "NHS England" throughout in the text, but define it to include Monitor and NHSTDA while they continue to exist); and

- made clear that the former remain in place until they are replaced by the latter (or are simply abolished) on the relevant Commencement Date.

5.5 The proposed changes to Contract wording giving effect to the above can be found chiefly in the Definitions section of the Contract, at the rear of the GCs.

5.6 Of necessity, this future-proofing approach involves a certain amount of imprecision or ambivalence in the wording of the Contract. Before we publish the final 2022/23 Contract, we will review whether the progress of the Bill through Parliament allows us to commit to more precise wording in some or all of the areas affected; failing that, we should be able to revert to more precise wording for the 2023/24 iteration of the Contract.

**Planning and collaboration at system level**

5.7 We propose to amend SC4.6 and Schedule 8 so that

- the language used will be consistent with duties on ICBs and Trusts described in the Bill and with the four strategic objectives set out for the NHS in the 2022/23 Priorities and Planning Guidance – that is, improving outcomes in population health and healthcare; tackling inequalities in

outcomes, experience and access; enhancing productivity and value for money; and supporting broader social and economic development; and

- the Contract wording refers to Joint System Plans (rather than the current term, Local System Plans), recognising the new arrangements in the Bill for "joint forward plans", covering a five-year period, to be agreed between an ICB and its partner Trusts and published.

5.8 For the last two years, as NHS system working has been developing, we have published a model System Collaboration and Financial Management Agreement (SCFMA). And there has been a Contract requirement (at SC4.7) that CCGs and partner Trusts must sign, and act in accordance with, an SCFMA, setting out how they will work together to manage NHS system finances.

5.9 With ICBs being formally established, along with new legal duties on ICBs and partner Trusts to work together to deliver system financial balance, alternative ICB governance arrangements (ICB sub-committees or joint committees with Trusts) will soon exist through which the aspirations set out in our model SCFMA can be delivered. In recognition of this (and in accordance with engagement feedback), we propose to remove from the Contract the requirement for CCGs and Trusts to sign up to an SCFMA – but we will continue to publish a model SCFMA which can be used where local systems wish to adopt it.

5.10 The Bill makes provision for an ICB to decide to delegate certain of its functions to an NHS Trust or an NHS Foundation Trust. Where an ICB, once established, determines that using this delegation provision would be beneficial for its population, there may be a case for recording the formal delegation agreement in a schedule within the NHS Standard Contract between the ICB and the relevant Trust. The provision in the Bill will be governed by secondary legislation and statutory guidance. The designate members of the ICB board, once appointed, will need to review and make their final decision on any such delegation proposals in accordance with this governing secondary legislation and relevant guidance once issued. At this stage, therefore, we have not included any new provisions in the Contract relating to delegation, but this is something we will look at further for the future.

**Changes to national quality standards**

5.11 As described in paragraph 6 below, we propose moving the national quality standards from Schedules 4A and 4B in the Particulars to a new location (Annex A) at the rear of the SCs. But we are also proposing changes to the content of the standards themselves, reflecting new and revised requirements set out in the 2022/23 Priorities and Operational Planning Guidance.

- We propose to amend the zero tolerance 30-minute standard for delays in handover from ambulance to A&E. Instead, we propose to set the zero

tolerance standard at 60 minutes, with additional requirements that (at least) 95% of handovers must take place within 30 minutes and 65% within 15 minutes.

- We propose to amend the zero tolerance standard for 12-hour waits in A&E, setting a requirement instead that (at least) 98% of patients must wait less than 12 hours.

- We propose to amend the zero tolerance standard for 52-week RTT waits, setting this instead at 104 weeks.

- We propose to include, for the first time, the national two-hour urgent response time standard for community health services, with a performance threshold set at a minimum of 70%, to apply from 1 January 2023.

- The Contract has for some years contained, at SC3.15, a reference to the Access and Waiting Time Standard for Children and Young People with an Eating Disorder. We now propose to move this reference to that it sits with the other national standards at the rear of the Service Conditions, with a performance threshold set at 95% for children and young people in need to begin treatment within 1 week for urgent cases and 4 weeks for non-urgent cases.

**Changes to reflect updated national policies**

5.12 This section sets out proposed changes which are aimed at promoting improvements in how care and treatment are delivered for patients, in line with the latest national policy direction.

| Topic | Change | Contract Reference |
|---|---|---|
| Midwifery services – continuity of carer | NHS England has now published new implementation guidance relating to midwifery continuity of carer. This moves away from setting, at national level, a specific target for the proportion of women who should receive continuity of carer. Rather, the focus has now shifted to the agreement of local action plans and trajectories, based on local circumstances and resources, for providing midwifery continuity of carer as the default model of care in maternity services. We propose to amend the Contract requirement at SC3.13 accordingly. | Service Condition 3.13 and Definitions |
| Interface with primary care | Detailed requirements for secondary care providers relating to their interface with local primary care services have been included in the Contract since 2017. They cover onward referral mechanisms, management of DNAs, discharge summaries and clinic letters, provision of medication, fit notes and dealing with patient queries. Implementation of these requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices. We therefore included, in the 2021/22 Contract, a requirement | Service Condition 3.16 |

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| | for the provider and the Co-ordinating Commissioner to undertake, by 30 September 2021 (and then annually), an assessment of the effectiveness of their interface working arrangements, with a specific focus on the provider's compliance with the Contract interface requirements – and to agree and implement an action plan to address any deficiencies, reporting this to their Boards. NHS England's winter plan for supporting general practice emphasises the continuing importance of this local process to improve interface working. For 2022/23, we therefore propose to amend the Contract wording slightly, to remove the specific 30th September 2021 deadline and, instead, refer to an ongoing annual requirement for assessment and action planning that builds on the progress made this year. | |
| Medical Practitioners Assurance Framework | The Government's response to the Paterson Inquiry has now been published. As part of the national response to recommendation 15, DHSC has asked us to consult on the inclusion in the Contract of a new requirement for providers other than Trusts to have regard to the Medical Practitioners Assurance Framework published by the Independent Healthcare Providers Network. The Framework aims to improve consistency in effective clinical governance for medical practitioners across the independent sector. | Service Condition 3.18 |
| Mental Health Units (Use of Force) Act 2018 | Regulations have been laid before Parliament to bring the Mental Health Units (Use of Force) Act 2018 into effect from 31 March 2022; final statutory guidance on implementation of the Act has also been published. The Act requires each provider of inpatient mental health and learning disability services to publish a policy on the use of force in restraining patients, to provide staff training on the appropriate use of force and to identify a senior "responsible person" to oversee its compliance with the Act. We propose to add a new obligation on providers to comply with these requirements. | Service Condition 3.19 and Particulars |
| Community pharmacy smoking cessation service | The Contract includes a requirement to screen inpatients for alcohol and tobacco use and to refer them, on discharge, to the relevant local authority alcohol advisory and smoking cessation services. A new smoking cessation service, provided by community pharmacies, comes on stream in the New Year, and we propose to broaden the requirement to include referrals to this new service, where available. | Service Condition 8.7 |
| NHS Discharge Medicines Service | To ensure better communication of changes to a patient's medication following discharge from hospital and to reduce incidences of avoidable harm caused by medicines, community pharmacies are now operating the NHS Discharge Medicines Service. We propose to include a new requirement on relevant providers to refer clinically appropriate patients into this Service, on discharge from inpatient care. | Service Condition 11.13 |
| Health literacy | We propose to add a new provision to require providers, when communicating with patients, to have regard to patients' levels of health literacy. It is important that information which providers make available to patients, in | Service Condition 12.4 |

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| | whatever format and through whatever means, is always clear and functional. That way, the up to 61% of patients who find healthcare terminology complex and confusing can nonetheless understand and engage with what is being said to them – and, ultimately, apply it to themselves in order to make informed decisions about their health and care. Further resources on health literacy are available here. | |
| National Quarterly Pulse Survey | The NHS People Plan made a commitment to introduce a new quarterly survey for NHS staff. In April 2021, the Staff Friends and Family Test was replaced by the National Quarterly Pulse Survey, and we have added a new requirement for Trusts to implement the National Quarterly Pulse Survey. (The requirement on all providers to carry out the Friends and Family Test Surveys in accordance with FFT Guidance is not changed.) | Service Condition 12.6 and Definitions |
| Antibiotic prescribing | The Contract has, since 2019, contained a requirement on Trusts to make 1% year-on-year reductions in their rate of total antibiotic usage – in accordance with the direction set in the UK National Action Plan (NAP) for antimicrobial resistance. We propose to make two changes to this requirement.<br>• The first is to limit its scope to the antibiotics in the World Health Organisation's (WHO) "Watch" and "Reserve" categories – no longer, therefore, including those from the "Access" category. This accords with the clinical priority ascribed by WHO and in the NAP to achieving higher reductions in the use of the broad-spectrum antibiotics in the "Watch" and "Reserve" categories. Making this change will remove any perverse incentive to reduce total antibiotic consumption by using one drug from the "Watch" or "Reserve" groups instead of two narrower spectrum drugs from the Access group.<br>• The second change, consequent on the first, is to re-set the reduction targets required in the Contract. The NAP sets an ambition to reduce the prescribing of antibiotics from the "Watch" and "Reserve" groups in hospitals by 10% from a baseline of 2017. The Contract requirement is set against the 2018 baseline, and to achieve the NAP 10% target now requires a cumulative reduction of 4% from the 2018 baseline by March 2023 and 6.5% by March 2024. We are confident that these revised targets are stretching but achievable, and we therefore propose to include them in the Contract. | Service Condition 21.3 and Definitions |
| Vaccination of staff against coronavirus and influenza | SC21.4 already includes a requirement on providers to use all reasonable endeavours to ensure that all frontline Staff in contact with Service Users are vaccinated against influenza. We propose to strengthen this for 2022/23 by<br>• expanding the coverage of the existing "reasonable endeavours" requirement so that it also covers vaccination for frontline Staff against coronavirus; and<br>• including a new requirement to comply with any applicable law and guidance relating to the deployment | Service Condition 21.4 |

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| | of Staff who have not been vaccinated against coronavirus. This will mean that the Contract supports implementation of the existing regulations and guidance which apply to staff deployment in care homes, as well as to any further regulations and guidance which the Government intends, following its recent announcement, to introduce in relation to staff working in NHS services more generally (see letters and guidance published by NHS England for further details). | |
| Assessment and treatment for acute illness | We propose to remove the requirement on providers to have regard to guidance relating to venous thromboembolism, catheter-acquired urinary tract infections, falls and pressure ulcers and provide an annual report to the Co-ordinating Commissioner on their performance in this area. This provision was introduced when the national Patient Safety Thermometer (which addressed the same clinical issues) was discontinued some years ago; but the advice of the NHSE/I Patient Safety team is that continuing to encourage a focus on these four specific “harms” to patients could result in an unhelpful “skewing” of what is reported to commissioners, detracting attention from what might be other more pressing local issues. | Service Condition 22.1 and Schedule 6A |
| Safeguarding | We propose amending the provisions relating to safeguarding to include specific reference to compliance with the Domestic Abuse Act 2020. (The Government has been consulting on draft statutory guidance to support implementation of the Act. If the final guidance is published in time, we plan also to include a reference to it in the final version of the Contract.) | Service Condition 32.3 |

**Changes relating to national care models and Primary Care Networks**

5.13 We propose to continue to strengthen requirements on providers to work with commissioners, Primary Care Networks (PCNs) and others to establish new national care models for certain out-of-hospital services, as set out originally in the five-year framework for GP contract reform.

5.14 The Contract already includes provisions relating to the deployment by mental health providers of **additional mental health practitioners** embedded in PCN teams. As set out in Supporting General Practice in 2021/22, our intention is that the numbers of embedded staff could increase further in 2022/23, but the details of this are subject to discussion at national level between NHS England and GPC England. At this stage, therefore, we have retained only the existing 2021/22 Contract provisions (at Service Condition 4.10 and Schedule 2Aii). We will share further details and drafting as soon as possible, so that commissioners and affected providers have the opportunity to review and comment.

5.15 As set out in the 2022/23 Priorities and Operation Planning Guidance, the new national Anticipatory Care operating model will be rolled out from 2023/24. During 2022/23, systems will therefore need to work with a range of

local providers, including PCNs, community health services, social care, mental health providers and acute providers to design, develop a system plan for and commission delivery of Anticipatory Care, in line with the forthcoming national guidance. We will publish an example Anticipatory Care service specification; this will be available for adaptation and use locally during 2022/23, and it is anticipated that it will then become part of the Contract for 2023/24.

**Changes relating to facilities and the environment**

5.16 This section sets out proposed changes in provisions of the Contract relating to green NHS issues and NHS facilities and estates.

| Topic | Change | Contract Reference |
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| National Standards of Healthcare Cleanliness | We propose to add a requirement to comply with the National Standards of Healthcare Cleanliness published in April 2021. These standards apply to providers of all NHS-funded services. Separate guidance sets out timescales for implementation. | Service Condition 17 and Definitions |
| NHS Premises Assurance Model (PAM) | We included, in the 2021/22 Contract, a new requirement on Trusts to complete the safety and patient experience domains of the NHS PAM. As part of the planned roll-out of the PAM, we now propose to expand this requirement to cover all five PAM domains – safety, patient experience, efficiency, effectiveness and organisational governance. | Service Condition 17.9 |
| Green NHS | We intend to continue to strengthen the requirements in the Contract on green issues, in line with commitments set out in Delivering a 'Net Zero' National Health Service. Proposed changes are set out below.<br>• Providers have already met the target of 90% of their fleet being "low-emission". Accordingly, in line with the NHS Long Term Plan commitment, we propose to change the Contract to require transition to "ultra-low and zero emission" vehicles as quickly as reasonably practicable.<br>• In support of this, we propose to add a new requirement on providers to develop plans to install electric vehicle charging infrastructure for fleet vehicles at their premises.<br>• We propose a new requirement on providers to ensure that any car leasing schemes for staff (including salary sacrifice schemes) do not allow use of high-emission vehicles.<br>• Providers have met the target of reducing the proportion of desflurane to volatile gases used in surgery to 10%. As set out in Delivering a 'Net Zero' National Health Service, we now propose to reduce the Contract target for desflurane use to 5% or less.<br>• We propose to add a requirement on Trusts to adhere to the requirements set out in *Taking Account of Social Value* (Cabinet Office | Service Condition 18 and Definitions |

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| | Procurement Policy Note 06/20). This will mean that, in any tender evaluation a Trust undertakes, it will need to place a minimum 10% weighting on criteria related to social value. | |
| Car parking | We have updated the definition of NHS Car Parking Guidance to reflect the latest national position published at https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles/nhs-patient-visitor-and-staff-car-parking-principles. | Definitions |

**Changes relating to the NHS e-Referral Service and to patient choice**

5.17 This section sets out proposed changes in provisions of the Contract relating to use of the NHS e-Referral Service to the operation of the legal right of patient choice of provider.

| Topic | Change | Contract Reference |
|---|---|---|
| Listing of services on eRS | We have become aware of instances where providers are listing their services on the wrong "menu" within the NHS e-Referral System (e-RS). Under e-RS, there are two options:<br>• the "secondary care menu", for services to which the legal right of choice applies under the NHS Choice Framework and which must be made available to referrals from all CCGs/ICBs in England; and<br>• the "primary care menu" for services outside the scope of the legal right of choice, which have been commissioned specifically by one or more CCGs/ICBs and which must be made available to referrals from those CCGs/ICBs only.<br>It is essential that services are made available on the correct menu, and we propose to add a specific requirement on providers to ensure this, in consultation with the relevant CCGs/ICBs. | Service Condition 6.4A and Definitions |
| Use of e-RS for mental health services | The Contract has, since 2019, included an obligation on providers of elective mental health services to list their services on e-RS. We recognise that – while moving towards use of e-RS for mental health services remains the national direction of travel – many providers have not been able to make significant progress on this during the pandemic. We therefore propose to soften the contractual requirement slightly, so that the provider must use "reasonable endeavours" to list its services on e-RS. | Service Condition 6.4 |
| Legal right of choice of provider | The Contract includes provisions at SC6.8 which require that providers must accept all referrals / presentations which give effect to a patient's legal right of choice or which are for emergency treatment – even where the patient's responsible commissioner is not a direct party to the provider's contract. SC6.13 then makes clear that, in other circumstances, a provider has no entitlement to be paid for providing services to patients whose responsible commissioner is not a party to the contract. | Service Condition 6.13 |

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| | For the legal right of choice to apply to a particular service, the provider must have been commissioned to provide that service by at least one CCG/ICB. And the provider can then offer the service to other CCGs/ICBs only as commissioned – that is, on the basis specified in the provider's contract with the first CCG/ICB. We have become aware of instances where providers believe, incorrectly, that the fact that they have a contract for a service provided in location A allows them, automatically, to offer that service in location B. That is not the case, and we have proposed amendments to SC6.13 to make this explicit. | |

**Other smaller changes**

5.18 We propose to make a number of other smaller content changes.

| Topic | Detailed change | Contract Reference |
|---|---|---|
| Standards for Inpatient Mental Health Services | We propose to add a requirement on providers of mental health and learning disability to have regard to the Standards for Inpatient Mental Health Services published by the Royal College of Psychiatrists. | Service Condition 8.9 Definitions |
| Use of the Lester Tool | The Contract already includes a requirement on providers of mental health and learning disability services to monitor the cardiovascular and metabolic health of Service Users with severe mental illness, in accordance with the Lester Tool. We propose to amend the Contract wording to make it clear that this also applies to service users who also have a learning disability, autism or both and who are receiving anti-psychotic medication. | Service Condition 8.9 |
| Local Incentive Scheme | We propose to remove the separate arrangements for Local Incentive Schemes in SC38 and Schedule 4D, which we believe are redundant. The national financial incentive scheme, CQUIN, applies to those contractual relationships which fall within scope of the Aligned Payment and Incentive rules in the National Tariff Payment System and is documented in Schedule 5E. Any other agreed arrangements for financial incentives should be recorded in Schedule 5A (Local Prices). | Service Condition 37 and Schedule 4D |
| Infection Control and Prevention | The Contract includes a zero-tolerance standard for MRSA infections and requires Trusts to achieve annual targets to minimise rates of C difficile and gram negative bloodstream infections. These arrangements remain unchanged, but the definitions for these standards and targets will now be published at https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/, rather than in Appendix 2 of our Contract Technical Guidance. We propose to amend the Contract wording to reflect this. | Service Conditions Annex A |
| VTE risk assessment | We propose a change to how the standard for venous thromboembolism (VTE) risk assessment for inpatients is measured. Rather than the provider being required to report | Service Conditions Annex A |

| Topic | Detailed change | Contract Reference |
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| | on its performance across all inpatients, as currently, we propose that this should in future be quarterly and sample-based, as is the case already with the standard for sepsis screening. Making this change will reduce the reporting burden on providers. We will discuss, with NHS Digital, associated changes to the current VTE Risk Assessment Collection (currently paused owing to the pandemic). | |
| Service Specifications | We propose to streamline the current Contract template for service specifications. In many cases, specifications in contracts should be less restrictive and input-driven in future than is often the case currently, allowing the provider more leeway to adapt and refine over time how services are best delivered to meet the commissioner's long-term objectives and desired outcomes. The proposed changes here can be found in Schedule 2A of the Particulars. | Schedule 2A |
| Aligned Payment and Incentive Rules | We propose to make minor changes to reflect updates to the Aligned Payment and Incentive Rules set out in the proposed 2022/23 National Tariff Payment System. | Service Condition 36.21<br>Schedule 3D and Definitions |
| Procurement of emergency ambulance vehicles | The Contract already includes, at SC39.4, a requirement for ambulance Trusts to source new double-crewed base vehicles and conversions in accordance with a national specification (the National Ambulance Vehicle Specification) and through a national supply agreement (the Compliant Ambulance Vehicle Supply Contract). The supply agreements have now been put in place; we propose to update the Contract definition to reflect this. | Service Condition 39.4 and<br>Definitions |
| Guidance on Care of Dying People | We have updated the definition of Guidance on Care of Dying People to include references to relevant NICE guidance. | Definitions |

5.19 We have made other minor changes to rationalise and improve the Contract where we have considered it appropriate to do so.

## 6 Online presentation of the Contract

6.1 We are proposing a set of changes so that the General Conditions and Service Conditions of the Contract would no longer need to be exchanged between the local parties as part of their local agreement. Rather, the GCs and SCs would exist solely in their up-to-date online form, as published by NHS England from time to time; they would be incorporated into, and would apply automatically as part of, each local contract by reference only. The only element of the Contract exchanged between the parties locally would be the Particulars, which set out the locally agreed elements.

6.2 Our outline proposal to make this change received strong support in our engagement process. We believe that it will simplify the presentation of the Contract, making it easier for those using it to focus on the key elements they need to complete locally. It will contribute to the NHS green agenda, in that the GGs and SCs (which, together, comprise over two-thirds of the content of the Contract mandated by NHS England) will not need to be printed locally. And it will mean an end to the need for National Variations by which the national terms of multi-year contracts have to be updated locally, thus cutting out a time-consuming local administrative process.

6.3 The proposed changes are given force, chiefly, by new wording on page 7 of the Particulars and by amended definitions of the GCs and SCs. But, to make the new arrangements work, we have proposed two further material changes.

- We have removed, from GC13, references to the National Variation process. Instead, any changes published by NHS England to the GCs and SCs will apply automatically from the date of publication or whatever later implementation date may be specified in the wording of the relevant GC/SC. If a provider no longer wishes to provide services on the basis of the updated national terms, it will – as now – have the option to terminate its contract, on notice, on a “no fault” basis under GC17.

- We have moved the nationally mandated content previously in Schedules 4A and 4B (national quality standards) and Schedule 6F (provider data processing agreement) into a new section (Annexes A and B) at the rear of the Service Conditions. This will allow NHS England to update these national terms from time-to-time as necessary without requiring parties to contracts to update their own Particulars. The elements which require local completion (local quality requirements and the details of any specific data processing services) remain in the Particulars.

6.4 Two related points should be emphasised here.

- The existing “order of precedence” within the Contract remains unchanged. As set out in GC1, the GCs take precedence over the SCs which in turn take precedence over the local content in the Particulars. So, as now, it will not be possible for local parties to set aside or depart from the national provisions of the GCs and SCs by seeking to agree alternative wording in the Particulars.

- As currently, NHS England will consult formally on any proposed material changes to the GCs/SCs. No material changes will be made to the GCs or SCs without input from stakeholders, and no changes will be introduced without prior notice. We envisage that the process for consultation and updating the GCs and SCs will remain annual, other than where there is an urgent need for an in-year change, as has been the case since 2013. There is no intention that the content of the GCs/SCs will become subject to rolling in-year updates.

6.5 The move to online presentation described above would mean that NHS England would no longer make available the current eContract system. (The eContract system allows a "tailored" version of the SCs to be produced and printed locally, including only those provisions which are relevant in the case of a specific provider – but this would be redundant under the online approach.) This would have two consequences.

- We would retain, in the SCs, the current arrangement for "tailoring" of the applicability of Contract provisions using service categories (acute, mental health etc) to denote whether or not the clause applies to the contract in question. Contract clauses which were not relevant to a specific provider, because it did not provide the services to which those clauses apply, would simply be "read over" as not applicable.

- Other aspects of "tailoring" (for example, where a provision applies only to a provider which is a Trust and not to other providers) would, in future, be dealt with through the actual Contract text, rather than through the "applicability" column of the SCs. As a result, we have been able to propose some further simplifications of the Particulars, removing detail which was previously included simply to drive eContract "tailoring". This will again help to make the local process of completing contract documentation simpler and less time-consuming. See pages 10-13 of the Particulars for further detail.

## 7 The shorter-form Contract

7.1 A small number of the changes described in section 5 above are also appropriate to include within the shorter-form version of the Contract. These changes relate to:

- adapting the Contract to reflect the Health and Care Bill
- vaccination of staff against coronavirus and influenza
- the National Standards of Healthcare Cleanliness
- Anticipatory Care
- community two-hour response time standard
- online presentation of the General Conditions and Service Conditions.

7.2 The shorter-form Contract remains significantly 'lighter-touch' than the full-length version. Our Contract Technical Guidance continues to describe the situations where use of the shorter-form Contract is encouraged – as well as those for which it is not designed.

## 8 Low-volume flows of activity

8.1 We have been working for some time to streamline financial processes for managing low-volume activity flows (LVA) from commissioners to distant Trusts. This was the subject of specific consultation a year ago on potential changes to the Contract and to CCG allocations.

8.2 Under the temporary COVID financial framework, there has been no requirement for Trusts to invoice distant CCGs. This reduction in transactional cost and burden has been universally welcomed, and our recent engagement with local systems on this issue confirms a strong desire not to revert, from April 2022 onwards, to a situation where a large volume of very low-value invoices have to be transacted.

8.3 On this basis, we are introducing new arrangements for LVA flows, for NHS Trusts and NHS Foundation Trusts only, to take effect from 1 April 2022. The arrangements now proposed are simpler than those on which we consulted last year and do not require changes to the national provisions of the Contract in the same way. They are described in the finance and contracting annex to the 2022-23 Priorities and Operational Planning Guidance and in paragraph 25 of our Contract Technical Guidance.

## 9 Consultation responses

9.1 We invite you to review this consultation document and the two draft Contracts (available on the NHS Standard Contract 2022/23 webpage) and provide us with feedback on any of our proposals. Comments can be submitted via an online feedback form.

9.2 **The deadline for receipt of responses is Friday 28 January 2022. We will publish the final versions of the generic Contract (both full-length and shorter-form) as soon after that as possible.**

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by NHS Standard Contract team, Primary Care, Community Services and Strategy Directorate.