

NHS STANDARD CONTRACT 2017/18 ENGAGEMENT SUBMISSION

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. NHS Providers has over 94 per cent of all trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.

We are providing a response on behalf of the sector to the call for feedback issued by NHS England, for proposed essential changes to the Standard Contract for 2017/18.

NHS Providers welcomes NHS England's contracting priorities for 2017/18, and considers that in addition, the following policy areas require essential examination for 2017/18:

- 1 NHS England must ensure timely publication of key contracting documentation and alignment with national tariff proposals;**
 - 2 NHS England must review the provider fines regime against the core quality standards, and as an interim measure, must stipulate a contractual obligation on the part of commissioners to reinvest withheld funding;**
 - 3 NHS England should re-evaluate its dual role as direct commissioner and setter of commissioning rules.**
- In conjunction with this re-evaluation, NHS Providers advocates the following essential measures:
- **An improvement in engagement with the provider sector by NHS England as a whole, with respect to policy affecting contracting;**
 - **Improved management of commissioner and provider affordability and activity plans, ensuring expectations are fair and reasonable across the system;**
 - **A re-assessment of the principles and practice of the CQUIN and QIPP schemes.** We acknowledge that the CQUIN scheme is not positioned within the Standard Contract. However, for some providers, CQUIN is considered as difficult a factor as the delayed publication of documentation in their commissioning discussions with NHS England.

Section one provides our view on NHS England's contracting priorities for 2017/18, and outlines our recommended essential changes to the above key areas in greater detail.

Section two outlines our recommended essential technical changes to the Standard Contract and Technical Guidance.

SECTION ONE

Our view on NHS England's contracting priorities for 2017/18

New Contracting Models to deliver New Models of Care

We strongly welcome NHS England's commitment to developing tailored contracts and contracting models in order to deliver the new models of care, and acknowledge that NHS England has responded to our previous consultation submission which called for the pace of development of new contracting forms to be accelerated. We welcome the

recent release of the MCP emerging care model and contract framework and we look forward to working with NHS England as the draft contract is developed, and as further frameworks are developed for other, remaining new care models. We are confident this contracting priority will prove invaluable as vanguards progress onto the next phase of implementation, as outlined in the *Five Year Forward View*, and we reiterate our offer of full support in order to assist with the delivery of this work stream.

We also offer our full support in facilitating the development and implementation of more multi-annual contract models, and multi-year CCG funding allocations where these would be beneficial for members. We believe that a focus on outcomes-based commissioning, and a shift towards multi-year contracting, will be well received by the sector and will help to improve the level of stability in the system.

Engagement on the NHS shorter-form Contract

We welcome the opportunity to work with NHS England on the shorter-form Contract during autumn 2016.

Key policy areas requiring essential change

We welcome the early opportunity to feed back on the Standard Contract, noting that this year's request is 2 months earlier than last year.

1 NHS England must ensure timely publication of key contracting documentation and alignment with national tariff proposals.

As mentioned in our consultation submission in the spring, the delayed publication of key documentation continues to be the element which has the most negative impact on the annual contracting round.

According to our recent survey of providers¹, 100 per cent of respondents called for the 2017/18 Standard Contract and technical guidance to be published by December 2016 at the latest, in order for providers to reasonably deliver their contracts by the statutory deadline.

Therefore we welcome that NHS England has committed to bring forward the annual planning round and to align delivery of the Standard Contract documentation with the national tariff. We strongly welcome the proposal to help system stability by extending national planning to a two year cycle for 2017/18 and 2018/19. However we would also wish to see NHS England identify appropriate opportunities and mechanisms for any necessary inter-year contracting adjustments, and look forward to engaging with NHS England to ensure that the right balance is struck between stability for future planning and flexibility to adjust to major changes.. We also recommend that relevant guidance relating to mandatory SDIPs and the CQUIN and QIPP schemes is further clarified and published earlier. For example, the release of CQUIN guidance was delayed to March 2016, by which point some negotiations between commissioners and providers had concluded. This creates an adverse effect as both commissioners and providers are already pushed to operate within tight timescales. We also seek to clarify whether NHS England propose to move CQUIN to a two-year basis, in a similar vein to SDIPs.

2 NHS England must review the provider fines regime against the core quality standards.

¹ We surveyed 29 providers from across the provider types of acute, ambulance, mental health and community trusts and foundation trusts, during the period 1st - 15th July 2016 (available upon request - a full report will shortly be published on our website).

We agree with NHS England's decision to suspend fines for those providers who have sought access to the Sustainability and Transformation Fund (STF) in 2016/17. However we maintain that the effectiveness of punitive contract sanctions must be given serious scrutiny, and continue to urge NHS England to reconsider their policy position on fines for 2017-19. Particularly in light of the current degree of financial uncertainty across the sector, we believe the lack of transparency with respect to the reinvestment of fines inhibits true 'place-based' collaboration.

NHS Providers maintains that fining, or withholding funds via the non-receipt of sustainability funding, remains an ineffective means of incentivising providers to improve performance. We do not believe that permanently withholding funding incentivises performance, but exacerbates the numerous financial challenges which trusts face, and denies providers access to the crucial funds they require to remedy existing issues.

If fines are maintained our members strongly feel that there must be a contractual obligation, rather than simply a recommendation, that commissioners to reinvest fines towards the improvement of services which are not meeting national targets.

3 NHS England should re-evaluate its dual role as direct commissioner and setter of commissioning rules.

We have consistently highlighted it is imbalanced that NHS England is both a direct commissioner as well as the body responsible for setting commissioning policy. We consider this to be a fundamental conflict of interest which impedes progress towards redressing the balance of financial risk between commissioners and providers. We continue to call for a fundamental review of the checks and balances on decision making within NHS England, particularly with respect to the legitimacy of changes to business rules, and imposition of mandatory policy.

We believe the following measures must be carried out in conjunction with such a re-evaluation:

- **An improvement in engagement with the provider sector, by NHS England as a whole**, with respect to policy affecting contracting. We recognise that NHS England's contracting team continues to improve its engagement with the sector. However we believe that NHS England could improve on issues such as transparency and sharing information that could provide greater clarity.

For example in the contracting round has just passed, clearer guidance could have been given to providers on the rules and deadlines for entering arbitration. We believe that improved information sharing – in an accessible and timely fashion - would enhance the ability of NHS England's local teams to carry out local-decision making and improve cross-sector collaboration.

- **Improved management of commissioner and provider affordability and activity plans.** We believe there needs to be improved provisions and incentives within the Contract and guidance to ensure appropriate levels of demand are commissioned. We therefore maintain that greater oversight of commissioning performance by the national bodies is needed to hold commissioners to account on this issue.
- **A re-assessment of the principles and practice of the CQUIN and QIPP schemes.**

According to our recent survey², which indicates that 59% of respondents found this year’s contracting round more difficult to manage than last year, respondents have found the CQUIN scheme to be as difficult a factor as the delayed publication of documentation in their commissioning discussions with NHS England.

We appreciate that the CQUIN scheme is designed to incentivise quality improvement, innovation and more efficient and productive delivery of care. While we acknowledge that the CQUIN scheme in itself is not strictly positioned within the Standard Contract and technical guidance, in effect, the impact of the scheme has continued to add significant difficulty to the contracting round and has consumed a considerable amount of providers’ time and resources.

We recommend NHS England devotes serious scrutiny to CQUIN, on the grounds that many within the provider sector no longer perceive the scheme to fit the original purpose of offering clear and direct financial incentive for providers to deliver clinical quality improvements and drive transformational change:

- **Robust evidence of benefits to clinical quality and innovation.** We firmly believe CQUIN design should be based on clear evidence to support the delivery of clinical quality. Improvements should be made to the design of indicators and criteria regarding the evidence providers must produce for local CQUINs with more realistic and achievable targets for providers.
- **Guidance.** This must be clear and timely, ensuring any changes to national guidance are in sync with CQUIN requirements and that both commissioners and providers are notified via email notification, in addition to the updates published on NHS England’s website. We also ask for improved clarity with respect to providers’ ability to locally negotiate national mandated instructions, and believe a clearer case for the benefits to clinical quality will reduce the time and resources spent negotiating.
- **Engagement and consultation.** We believe deviations from practice in previous years, including binding changes, should require consultation with the provider sector. For example, (for example, for those providers which are not Hepatitis C virus (HCV) Operational Delivery Network leads, this reduced from 2.4 to 2.0 per cent of the applicable contract value³).
- **Imbalance of risk.** We remain concerned that there has been a significant shift of financial risk to providers, regarding the continued use of CQUIN to achieve commissioner QIPP targets.

SECTION TWO

Essential technical changes to the 2016/17 Standard Contract

Contract Reference (where applicable)	Issue/Area	NHS Providers Feedback
Schedule 4B and SC4	Mental health access standards (covering Early Intervention in Psychosis and Improving Access to Psychological Therapies)	NHS Providers remains opposed to introducing additional fines into the Standard Contract and would recommend that fines against these standards are not introduced in any future year. The mental health Service Development and Improvement Plans (SDIPs), mandated to ensure providers are in a position to deliver these standards, should not be viewed as fait

² Ibid

³ <https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf>, p. 17

		<p>accomplish that fines should be introduced against these areas.</p>
GC9	Contract Performance Notices (CPN) and Remedial Action Plans (RAP)	<p>NHS Providers maintains that the provisions in GC9 still require substantial review in order to ensure a fairer balance between the interests of both commissioners and providers.</p> <p>We also recommend that the RAP fines are reviewed. The maximum withholding in relation to each RAP sanction is capped at 10 per cent of a provider's Actual Monthly Value. In addition, the sanctions in respect of Operational Standards and National and Local Quality Requirements are capped at a maximum of 2.5 per cent of Actual Quarterly Value. Taken together, this means the total potential fines liable on a provider who has not signed up to the STF and has entered a RAP in order to resolve performance issues, are significant. This is in addition to the potential information breach fines (SC28.19), capped at 5 per cent of Actual Monthly Value.</p> <p>We believe this level of financial risk causes providers undue concern and delay. NHS England must review these terms as there is financial redress for commissioners from providers, when providers have breached the plans, but no equivalent requirement on commissioners when they are in breach. The maintenance of RAP fines for 2017/18 is also at odds with the need to ensure financial sustainability for providers, as there is a risk that commissioners could use these provisions to continue withholding money from providers.</p> <p>While we believe the level of fines requires review, as an interim measure, we would recommend that NHS England clarifies technical guidance to make clear that fines written into the relevant schedules must apply on paper as well as in practice.</p>
SC28	Counting and coding changes	<p>NHS Providers believes the stipulation that counting and coding changes must be cost neutral for 12 months, following a 6 month notice period being given, requires review (SC28.11; technical guidance 43.22). It would also be helpful to have further clarity on what does and does not require notice being given.</p>
SC36	Payment terms	<p>We recommend that NHS England considers a mechanism to allow providers to be paid promptly (within a set timeframe) for legitimate activity while national or local funding disputes between NHS England and CCGs are resolved.</p> <p>This is particularly important given that compared to previous years, there is less working capital available for providers to act as a buffer against the delays in payments caused by prolonged disputes between commissioners.</p>
	Service Development Implementation Plans (SDIPs) – seven day services, mental health access standards, digital transformation and e-referral	<p>Providers are fully engaged in the SDIP planning process; however remain concerned that they will be pushed into incurring significant material costs in delivery.</p> <p>NHS England should explicitly clarify the nature of, and calculations underpinning, the proposed adjustment for service development detailed in the Tariff Engagement Document (section 3.2) and clearly communicate through the 2017/18 standard contract documentation and guidance how the mandated, locally agreed SDIPs will be funded within tariff.</p>