Draft 2013/14 NHS Standard Contract – ECCA Comments

Introduction

Thank you for the opportunity to comment on the draft NHS standard contract for 2013 -14. As an introduction we would like to make two important points. Firstly, DH Guidance in respect of previous years' NHS Standard Contracts set out an expectation that the Contract should underpin **a partnership of equals between Commissioner and Provider**. In order to ensure that the Parties are absolutely clear about this, a statement on this matter should be included within the Contract itself.

Secondly, we do not believe NHS Commissioners should each insist on their own formats for data reporting but instead show a degree of tolerance in accepting alternatives. It can be a real problem for providers especially large corporate providers contract with many different Commissioners. Furthermore, there does appear to be a desire to have all providers comply with a wide range of NHS guidelines/standards and procedures and this could have a negative impact on homely environments and their autonomy. Care homes are peoples' homes. Constant reference is made to NHS standards, documents and systems of work throughout the general and service conditions, requirements which may often apply to a home that may have only one or two residents to whom the contract applies. For example, there is a lot of concern and feedback from members concerning the IG Toolkit. The amount of time needed to complete the documentation is completely disproportionate. It will require care homes to take on new staff and commit considerable extra resources to undertake yet, we believe, offers no real additional benefit to people in care homes. Some of the requirements especially in LD are counter intuitive to standard LD procedures. We would also make a particular plea here for considered use of CQUIN, and ensuring the targets set in CQUIN are jointly discussed and agreed with providers. Some CQUIN targets and information requirements produced without provider involvement are clearly designed for NHS environments rather than care homes and can be extremely complex to deal with on that basis, and of little practical support to residents. We have seen examples of good practice too which we can share.

There is no doubt as a provider that an agreed national contract would be much easier to administer since the organisation would be clear from the outset what it is required to comply with. This would negate the current local variations.

The move to e-procurement is also a positive move and easier to administrate since the same information should be required regardless of which contract you are bidding for.

It is unclear how enhanced packages will be negotiated and providers need to be clear about this before entering into a contract.

Appendix 1 - Key revisions to the 2013/14 NHS Standard Contract

This Appendix makes no mention of potentially one of the most fundamental revisions to the Contract, viz. the removal of the mandatory condition that the Contract would have a duration of not more than one-year (previous versions of the Standard Contract incorporated a defined expiry date of no later than 31st March of the year in question).

"Contract Term" is defined as *the period specified as such in the Particulars*. However, the Particulars provide no clear details of the Contract Term. The Particulars make reference to "Expiry Dates" to be listed separately if provision of individual services is to expire before the end of the (unspecified) Contract Term.

If the Commissioner and Provider are expected to agree between themselves the Contract Term, then the Contract should make this clear.

If the Contract Term is to last more than one year, then the Contract must be made more robust, not least in respect of prices, where a clear, transparent and equitable mechanism should be included to ensure that legitimate changes in the cost of providing the Services are covered by appropriate changes in price either annually, or in response to changes in legislation / regulation which have a material impact upon the Provider's costs.

Service Conditions

We welcome the service conditions section specifying what service each clause relates to. However it is not clear which grouping care homes come under (presumably primary care or community services).

SC1 Service Standards should be redrafted to ensure that it properly reflects a partnership of equals and where the rules of natural justice are adhered to. Attention must be paid to ensure that the rights and best interests of service users are fulfilled. For example, the provisions of Clause 1.4 do not reflect natural justice (i.e. where Service Users may be removed from the Service purely on the basis of the opinion of the Commissioner). The terms must incorporate the need for evidence, the right of the Provider to reply / answer allegations, risk assessments to be undertaken and best interests consultations to be undertaken with Service Users.

The Contract must be drafted to ensure that the Commissioner acts reasonably and proportionately at all times. The Contract should reflect the Government's expectations regarding the handling of Safeguarding incidents as detailed in Gateway Reference 16072.

It would be helpful if 'Care Home' listed in 'The Services' under 'Particulars' A4 is defined under 'Schedule GC1 – Definitions and Interpretations'. This would then emphasise the person focussed nature of care, and that care homes are permanent homes to most of their residents and to differentiate residential care from nursing care.

SC2 specifies that the Provider must have and at all times maintain an up-to-date CRS Continuity Plan and Essential Services Continuity Plan. This should be reworded in order to acknowledge that it is possible that the Provider may not actually be providing any Essential Services.

SC3 although the consideration of Patient Choice is more likely to place obligations upon the Commissioner, certain clauses seek to apply only to the Provider. These need to be revised to ensure that the Commissioner's obligations and/or particular providers are made absolutely clear. For example the section refers to providers publishing services details and information in choose and book. It also states that referrals will be made via the choose and book system and that providers must offer clinical advice and guidance to GPs on potential referrals, whether this leads to a referral being made or not. It says that this is designated as ALL in the service conditions; We believe this may be an error and is something the acute sector would use re booking appointments etc. If this had to be implemented within care homes, consideration needs to be given to IT compatibility, time commitment and de-personalisation.

SC4 suggests that all Providers will be obliged to accept any referral of a Service User unless permitted to reject the referral under Service Condition 4. This is not correct – for example, under existing Framework Agreements, Providers of fully-funded NHS Continuing Healthcare have no such obligation. Similarly, Service Providers have no obligation to consider complaints as to why they have decided not to accept a Service User.

SC5 5.2 Clarification should be sought on how and who the provider will notify the referrer without delay out of hours – currently no CHC out of hours provision.

SC8 suggests that the Provider must not transfer or discharge a Service User if this would be contrary to the Service User's human rights. As described above, the Contract must make it clear that the Commissioner's actions described in SC1 should not contravene the Service User's human rights.

SC10 suggests that unless provided otherwise in the Contract, the Provider must at all times and at its own cost provide all Equipment necessary to provide the Services in accordance with the Law. This is not necessarily correct, especially in respect of the provision of fully-funded NHS Continuing Healthcare where in accordance with DH Guidance, specialist nursing equipment should be provided by the NHS, rather than the Provider. SC10 should be redrafted accordingly to describe how unless

otherwise provided, the Provider shall provide all appropriate Equipment that it is required by Law to provide.

Under SC12, the provisions of Clause 12.2 should apply equally and reciprocally to the Commissioner.

SC14 14.1 This has not been designated a category in the service conditions, it needs to be established if this refers to all.

If the standard does refer to all care homes will be required to have an HCAI (health care associated infections) reduction plan in place reflecting local and national priorities in relation to HCAI including without limitation antimicrobial resistance.

Consideration should be given to how this will impact on the homely environment within care homes i.e. will they be required to have hand gels, not use tea towels etc.

SC21, Clause 21.2 seeks to turn recommendations into contractual requirements. This is not correct.

SC22 considers information requirements. These should be carefully reviewed in light of the Government's "Red Tape Challenge" to ensure that all unnecessary / duplicated reporting of information is eliminated. It follows that the provision of Clause 22.17 (under which the Commissioner have the discretion to withhold payments for "Information Breaches") should be revised. The provisions of Clauses 23.8 and 23.9 are examples of unnecessary reporting (i.e. the Provider is being asked to provide information to the Commissioner which the Commissioner should already be aware). Clarification needs to be sought on exactly what will be required and how onerous this may be on a service. (It appears to be in addition to a monthly activity report and CQUIN?)

Given that the terms of the Contract are to be agreed by both Parties, it is inappropriate that Clauses 23.16 and 23.19 should suggest that the Commissioner should be able to unilaterally vary the terms of the Prior Approval Scheme.

Clause 3.2.2 should make it clear that its provisions only apply to NHS Providers.

Under SC26, Clause 26.4 seeks to require the Provider to participate in the development of any local multi-agency safeguarding quality indicators and / or plan. As an equal partner, the Commissioner may request, not require the Provider to participate.

In previous versions of the NHS Standard Contract, the clauses in respect of prices were contained in the mandatory General Conditions. It is important that these important clauses remain as mandatory conditions and so they should be included within the General Conditions section of the Contract rather than the Service Conditions.

Under SC29, Clause 29.7 specifies that the calculation and basis of calculation of the Non-Tariff Prices must be transparent and equitable. As detailed above, if this Contract is to be sufficiently robust to last more than one year, it must include a

transparent and equitable mechanism to review prices in response to changes in the legitimate costs of providing the Services; "agreements to agree" are never particularly effective in a contract. Clause 29.8 suggests that the Commissioner and Provider must agree Non-Tariff Prices to apply to the following Contract Year. In the absence of a pre-agreed mechanism it is possible that the Commissioner and Provider will not agree. This is acknowledged in Clause 29.9 whereby non-agreement on price will be referred to Dispute Resolution and possibly termination of the Contract.

Clauses 29.26 and 29.27 are not correct and should be removed; the Provider has no statutory obligation to administer the Service User's statutory benefits.

Clarification is needed on the definition of a small provider, in regard to reconciliation report regarding monies paid will be provided by the commissioner.

General Conditions

GC6 (Regulatory Requirements) seeks to turn recommendations into contractual requirements. This is not correct.

The requirements in GC7 (Service User Involvement) should apply equally to the Commissioner.

GC8 (Co-operation) should be redrafted to reflect the fact that the Provider and Commissioner are equal partners. Although Clause 8.3.6 refers to the delivery of a *consistently high standard of care,* the Contract provides no explanation as to what this entails.

We very much welcome the statement in GC9 (Equity of Access, Equality and Non-Discrimination) that the Parties must not discriminate between or against Service Users on the grounds of age, disability, gender etc. The Commissioner should be required to ensure that its commissioning activities do not discriminate against certain groups (e.g. Older People or people with Learning Disabilities or Mental Illness). Clause 9.3 shall apply equally to the Commissioner.

Considering the fact the NHS produce information in numerous languages for those who do not speak, read or write English more transparency is required regarding what is considered to be a reasonable adjustment and appropriate assistance.

Given that this Contract should consider outcomes, not inputs, the terms of GC11 (Staff) should be revised to exclude matters which have no relevance to outcomes. In addition a number of these inputs will have to be reflected in Commissioner fee uplifts to avoid future capacity or quality problems in the sector.

The terms of GC12 (NHS Counter Fraud and Security Management) should make it clear that they apply only to NHS Providers.

The terms of GC14 (Review) could result in a disproportionate level of administration, especially where there is low activity under the Contract. Levels of

materiality should be set in order to avoid disproportionately high numbers of review meetings and reporting. We believe that in the great majority of cases 6 monthly is appropriate for review meetings.

GC14A suggests that a new NHS Standard Contract will be published in the following Contract Year. This is potentially inconsistent with the drafting of this Contract whereby it could last more than one year.

C15 (Contract Management) should be redrafted to reflect the fact that the Commissioner and Provider are to be equal partners. The procedures detailed in these clauses do not necessarily follow the basic rules of natural justice (for example, the Contract gives the Commissioner the right to withhold payments where a Remedial Action Plan has not been agreed, even though the Provider may have disputed the Contract Query which gave rise to the Commissioner seeking to apply a Remedial Action Plan. Furthermore, these clauses automatically assumes that the Remedial Action Plan is to apply to the Provider, even though it is possible that this may have arisen from the Provider issuing a Contract Query against the Commissioner for non-fulfilment of its contractual obligations).

Although Clause 15.1 refers to Schedule P4 (Quality Requirements), this Schedule has not been included in the draft Contract.

15.11 We believe that withholding (2%) of monthly sums for each further month RAP is not agreed is disproportionate. This is risky for providers (especially smaller ones) who have already squeezed all the efficiency pips and may not have the working capital to withstand this financial burden.

Clause 15.25 has been drafted the wrong way round. It should be the responsibility of the Commissioner to produce evidence to support its decision to withhold payment rather than the Provider having to produce evidence as to why payment should not have been withheld.

GC20 (Variations) considers how the Parties may agree to amend the terms of the Contract. Clause 20.2 explains that the Parties may agree to vary any of the Variable Sections – however, as defined only Section A (Particulars) may be varied.

The suggestion under Clause 20.10 that one Party's decision not to accept the other Party's proposed variation should trigger the Dispute Resolution procedure needs to be reconsidered. Failure to agree a variation should not be treated in the same way as a dispute arising from the operation of the existing (agreed) Contract terms.

GC22 (Governance, Transaction Records and Audit) requires redrafting in order to properly reflect equal partnership working and also to eliminate unnecessary inspection and administration.

Clause 22.1 requires substantial revision. The Provider's obligations to Regulatory bodies, the National Audit Office, Audit Commission, HealthWatch England etc. are already covered elsewhere and there is no need for this Contract to restate them. Furthermore, it is unreasonable for this clause to suggest that Authorised Persons (defined as the Nominated Commissioner and each of its Associates and any body

or person concerned with the treatment or care of a Service user approved by the Nominated Commissioner) should have the right to access the Provider's Premises (or the premises of any sub-contractor) without notice. The Commissioner is the Provider's equal partner, and all suggestion that the Commissioner should act as a pseudo-regulator (duplicating the role of the Statutory Regulator) should be removed from the Contract. It is Good Practice that, in order to avoid unnecessary disruption to the Service and to Service users, contract monitoring activities should be undertaken by prior appointment.

The provisions of Clause 22.3 represent unnecessary duplication of reporting and administration.

Clause 22.4 seeks to turn recommendations into contractual requirements; this is not correct.

The requirements of Clause 22.6 and 22.7 are excessive and create unnecessary administration. The checking of non-Tariff Prices should be restricted only to ensuring that invoices are raised in respect of all Services provided and that payment of all of these invoices is made. The commissioning of an auditor specifically to undertake this function is disproportionate, as is the suggestion that the audit should extend to a detailed inspection of costs.

GC23 (Suspension) requires substantial redrafting in order for it to reflect equal partnership working and also to be consistent with the rules of natural justice (please refer to the recent judicial ruling in the case of Davis v West Sussex County Council (2012) EWHC 2152 (QB), (2012) MHLO 83). As defined a Suspension Event can arise solely as the result of the Commissioner's opinion; this opinion (however reasonable) could be wrong.

In seeking to prevent further Service Users being referred to the Provider during a Suspension Event, Clause 23.10 is potentially in conflict with the wishes of Service Users. The requirement that the Provider should not accept further referrals is potentially contrary to the rules of natural justice, especially where the Provider has been given no right to challenge the Commissioner's decision to suspend referrals.

Under GC24 (Termination), on the assumption that the Contract may be structured to last more than one year, unless adequate mechanisms are incorporated to ensure that changes in prices adequately cover changes in costs of providing the Services, the suggested notice period of 12 months is far too long.

Under Clauses 24.4 (Termination: Commissioner Default) and 24.5 (Provider Default), mechanisms must be built-in to safeguard the interest of Service Users. Any termination by the Commissioner must include the performance of risk assessments and best interests consultations with all affected Service Users. Clause 24.5.9 (failure to comply with General Condition 30 – NHS Branding, marketing and Promotion) is not relevant to non-NHS Providers; this should be made clear.

The conditions of Clause 25.2 represent an unreasonable level of risk to the Provider insofar as the Provider may have been providing the Services at a lower cost than

alternative providers. The suggestion that the Provider should reimburse the Commissioner for the additional cost of alternative provision is unfair.

Clause 25.4 should be redrafted to reflect the equal partnership between Commissioner and Provider (i.e. the Parties should *cooperate with each other* rather than the Provider having to *cooperate fully with the Commissioner*).

Clause 25.7 assumes that upon expiry or termination of the Contract all Services will cease to be provided. This is not necessarily correct; it may be the case that a new replacement contract is to be introduced and the Services shall continue.

GC28 (Data Protection, Freedom of Information and Transparency) refers to the Provider achieving a *minimum level 2 performance against all requirements in the relevant NHS information governance toolkit*. No further explanation is offered.

Under Clause 28.5, the Provider's involvement in FOIA should be limited to offering *reasonable assistance* to the Commissioner rather than *assisting and cooperating*.

The provisions of GC29 (Intellectual Property) require further consideration. Where a Provider develops its own IPR, it should have the right to decide whether it wishes to grant other bodies (including the Commissioner) the right to use it under licence.

The provisions of GC30 (NHS Branding, Marketing and Promotion) should apply to NHS Providers only.

ECCA 29th November 2012
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