NHS Standard Contract – Comments from ECCA

Question 1

Do you support our intention to retain the current three part structure for the contract for 2014/15?

There has been no strong feedback on the structure. The real issue is that the length remains too long and overwhelms many providers in terms of the understanding necessary to decide whether to proceed and sign the contract and, in any event, much of the contract relates to acute services and NHS standards.

There is little understanding of care home function and monitoring methods which would drive a positive outcome on service users well being, this is what needs to be addressed urgently.

The option for text to be inserted locally is somewhat concerning since this suggests that local variations may be imposed despite this being a 'national' contract.

Question 2

Do you support our intention not to make material changes for 2014/15 to the clauses of the contract dealing with contract management processes?

No.

The change from the care homes specific contract to the generic contract has not been easy. Most of the contract terms are not relevant (eg the choose and book system is not relevant to care homes) and the reporting requirements are unachievable.

All of the arguments that ECCA put forward in 2011 / 2012 once again need addressing and as a result the contract does need a review with the specific concerns of care homes and their residents in mind.

We believe that the contract assumes that care home providers have the necessary back office support to deal with the contract requirements. Most care homes, even if part of a larger group, will either not have the administrative support or, be required to recruit new staff when in reality the contract size may simply make this uneconomic. The contract needs to be proportionate to the setting.

Question 3

Do you support our intention to provide a contract with greater flexibility in terms of duration above, and do you have any comments on the specific details of the approach?

The structure of the contract is designed around short term episodic care (eg acute admissions and outpatient services) and not long term care - the contract expires in 12 months. If the provider refuses to sign the next version of the contract, is it really the case that the NHS will move CHC residents from their homes?

One local contract hasn't yet been changed to the 2013/2014 (as at July 2013) as it has been delayed, having had to go through various levels of the CCGs for agreement. If this is going to happen every year, it would certainly make sense for the contract to run for longer than 1 year BUT ONLY IF the contract is right! The contract does not currently reflect what actually happens in care homes and this needs to be urgently reviewed in conjunction with providers before extensions to contract duration are considered.

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.

A one year contract will not allow a care home to invest in the care facilities, staff and services to meet the demands of the contract. More importantly it cannot provide security to a person being cared for in the home who may be forced to leave the home after a year should the contract not continue, because of decisions around the burden of the contract, rather than the actual quality being at fault.

Longer term contracts provide additional security for providers and would assist providers to focus on providing a particular type of service delivery which in turn would enhance the quality of the service.

Question 4

Do you agree that the current contract can support innovative commissioning models such as the prime contractor approach? If not what changes do you think are needed?

We do not believe the contract encourages provider innovation and changes in activity. It is much too focussed on the acute sector, and shows little understanding of care homes. We would suggest that if a refusal by the commissioner to allow an innovation had adverse and unjustifiable consequences for residents then this may be subject to judicial review.

It could be argued there is a real danger it will stifle innovation, due to the focus on NHS standards many of which are inappropriate, excessive and not conducive to promoting a homely, person centred experience for service users.

Local initiatives seem to be progressing, irrespective of, and outside the contract, rather than by being supported by it. As CCGs are establishing themselves, there are numerous pilot schemes which purchase services from Adult Social Care Providers. The real shortfalls and deficiencies in the contract are not likely to come to light fully, until the CCGs begin to formally go out to tender for these new services.

Question 5

Can you suggest additional quality or service standards for other non acute services which could be reflected in, and possibly incentivised through, the contract in 2014/15?

We would strongly argue that before looking at additional quality standards there is a proper examination of the current standards in relation to social care registered care homes. We do not believe many of the current standards are appropriate for care home settings and as such would not support additional requirements until this issue is addressed and standards better reflect the care given in a care home setting.

Question 6

Is the current guidance on collaborative contracting sufficiently comprehensive, detailed and clear? If not, which specific areas and issues require further clarification?

The meaning of "collaborative contracting" is unclear.

If this means joint commissioning with local authorities, there is nothing to support this. The advice that has always been given is that the contract is only for 100% NHS funded care. If joint funded, then the council contract is used.

If the term relates to proper consultation and collaboration with providers, then this isn't sufficiently detailed or enforceable. Local NHS commissioners seem reluctant to consult in any meaningful way, and at best may hold information sharing meetings where providers are told what is happening. In a small number of areas, where there is strong representation from a local association, consultation is more meaningful, but the review of fees, the biggest single issue facing providers, is still a topic that NHS commissioners refuse to discuss or address properly.

Question 7

If an improved, more reliable and responsive econtract system is made available for 2014/15, will your organisation plan to make use of it for the majority of its contracts?

If all commissioners used this it would certainly make the process smoother for large care home operators with numerous homes across different commissioners.

Question 8

Are there types of contract or provider for which use of the NHS standard contract is proving particularly problematic? How can these problems best be overcome?

The bilateral care home contract is approximately 1,300 pages long, if one includes all the documents, guidance etc which the provider is obligated to either implement or have regard to. In itself, this makes the contract unfit for purpose, given the relatively trivial contract values and the small size of many providers.

Few providers possess the resources to check the entire 1,300 pages to ensure compliance, or advise the commissioner when they might be in breach, or to keep track of the continual changes. It is unacceptable to include references to other documents (other than laws or regulations) in any contract – ie the document should be completely self-contained – and any contract potentially worth as little as £40-50k a year shouldn't run to more than 50 pages (including specifications, appendices etc).

Another major issue is that the provider is obligated to comply with policies and guidance as amended from time to time. Such changes are imposed on the provider without any opportunity to review the cost implications and fees, which is wholly unfair. Some of the policy and guidance references are already out of date in the documentation providers are sent, so the references to what they have to comply with have changed before the document has even been signed.

Question 9

Do you agree that it would be appropriate to amend the payments terms clause, so that providers issue monthly reconciliation accounts, which each commissioner can then accept or contest?

This would create yet another tier of administration. A simple one page document should be sent by the commissioner, to the provider on a monthly basis, confirming that the payment details are correct. This is current practice, but in reality, when changes are sent back (usually regarding new placements or increases in fees) the commissioners administration systems do not update quickly enough to generate correct payments.

Given current issues with income this may assist if it was driven by something like the residents register for each home.

Question 10

Do you have suggestions for specific changes to the reporting requirements schedule of the contract, with a view to safely reducing the information collection burden?

Few CHC contracts are worth the resource requirements imposed upon the commissioner to monitor the compliance of the provider.

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, who 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. For example we understand that Somerset CCGs allow providers to use their own formats to reduce duplication since in many areas the same information about residents is being collected by several organisations like the CQC and Local Authorities.

The NHS are not the only purchasers seeking information from providers, consideration needs to be given to the cost and time implications this has for providers and the fact that since most purchasers are focussed on a paper driven exercise it brings no real value to the service user outcome.

Question 11

In terms of practical completion of the contract documentation, can you suggest ways in which this could be streamlined, eliminating any current requirements which are not seen as adding value locally? And do you have suggestions for the type of support you would like in understanding and using the contract?

The only way that this can be achieved is by reconvening the provider reference group. It is extremely frustrating to say the least that the work that we did 2 years ago has now apparently been thrown out completely. Following proper consultation, a great deal of the "to be determined locally" elements could be replaced with mandated elements. This would reduce the costs to the CCGs in developing local elements, but also assist in developing more consistency, which would be a huge benefit to providers.

A thorough review of the contract needs to be undertaken in conjunction with providers and a national care home contract produced.

The contract should then be presented in a series of national seminars

Question 12

Do you think that the contract gets the balance right, in terms of the extent to which existing guidance on specific policy areas is re-stated within it? Should specific content be removed. Or additional areas added?

In particular, ECCA has argued in the past that the contract should contain an obligation on providers to comply with statutory requirements, rather than incorporate all the NHS policies that implement those requirements. However, the DH suggested that NHS policies and guidance imposed a higher standard than statutory requirements, and therefore – for competition reasons – they had to be included in order to ensure a level playing field with NHS providers. However, when challenged to demonstrate where any of the policies set higher standards, no examples were offered.

The contract incorporates every major NHS policy that concern NHS provider bodies. This is problematic on three fronts. Firstly, they are generally too complex and lengthy to be effective, as they are written by people whose main concern is not being wrong, rather than helping the practitioners in the field. They are therefore a barrier to safe and effective care, rather than a help. Secondly, they are written with large acute NHS hospitals in mind, which means that their relevance to care homes is highly questionable. Thirdly, they are generally policies that affect the whole organisation of the provider, whereas the NHS is generally an ad hoc, minority purchaser of care home places (8% according to Laing & Buisson), which makes their relevance an even greater concern.

This focus about preventing things going wrong does not address the fact that in care homes risk based care is central because residents are encouraged to make

their own choices and to live their life as they wish. The management of risk is therefore a key feature and should be encouraged.

Question 13

Other aspects of the contract that need improvement?

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.

On the broader front, as a public body, the NHS is required to act reasonably and consult over changes. The right of the NHS to change terms and conditions in contracts without notice, much less consultation, is also unreasonable and is therefore in breach of the NHS's public law obligations.

Finally, it's probably worth mentioning to you that a significant amount of care is still being delivered in homes that do not have a contract for CHC. This is arising when people who are already living in a care home deteriorate, and become eligible for CHC. There are no "spot contract" arrangements in place to underpin this. The homes that have not gone through AQP are not bound by the contract, nor are they monitored. It also means that the providers of those service aren't eligible for CQUIN

Although the NHS CB's Technical Guide and Clinical Guide are useful, these are very NHS-centric

Discussion document 2

Review of incentives, rewards and sanctions

1.1 With regards to the "Review of incentives, rewards and sanctions" discussion paper, ECCA would definitely support a national service specification, but again, this is on the proviso that it is 'right', and that it is written in consultation with providers! Any national standards which exceed the CQC Essential Standards, should be set with the knowledge that rates paid must be increased to cover the additional costs. Many providers have once again had a zero increase for CHC this year, and there doesn't seem to be any avenue open to challenge these decisions.

1.2 Building capacity is simple if the right the right rates of return are paid new providers will come in to the market. Excess capacity will then sort out the poorer quality providers who will either fold or improve. At the moment, fees are being kept artificially low rather than reflecting actual cost of a good quality service. The CCGs locally, also need to share information about gaps in the market with local providers eg rehab / assessment beds to facilitate earlier discharge from hospital.

1.3 CQUIN definitely needs strengthening. 2.5% is about right, as long as the base line price covers the cost of the service. The difficulty that we are getting now is that providers need the CQUIN in order to cover costs.

1.4 One of the issues to consider about "local" solutions is that they are not really always decided at a local level. Large business support services are drawing up these things, with very little input from the CCGs This is exacerbated by the minimal knowledge within the CCGs of the issues around non NHS services.

ECCA would not "*support a national CQUIN in any of the following areas: staff satisfaction and clinical engagement; improvements in clinical audit".* All of these would require additional data collection and administrative burden. If we were to suggest anything, it would be something that providers have been doing around reducing hospital admissions and length of stay.

Financial sanctions are not always used locally, but the NHS follows the local authorities lead on suspension of placements.

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