

Draft NHS Standard Contract 2021/22: A consultation

Stakeholder response document

Version number: 1

First published: January 2021

Updated: NA

Prepared by: NHS Standard Contract Team
england.contractsengagement@nhs.net

Classification: Official

Publication Approval Number: PAR272

Introduction

The NHS Standard Contract is published by NHS England and is mandated, under Standing Rules regulations, for use by NHS commissioners when contracting for all healthcare services other than primary care. The Contract is published in two generic versions – the full-length version, and the shorter-form version.

NHS England is now consulting on proposed changes to both versions of the Contract. Draft versions of the Contracts are published, alongside a consultation document describing the main, material changes NHS England is proposing to make, on the NHS Standard Contract [2021/22 webpage](#).

1 How to respond

NHS England would welcome comments from stakeholders on the proposals, along with any other suggestions for improvement. Comments can be made either by using an [online feedback form](#) or by email to england.contractsengagement@nhs.net, using this template.

Full details of the proposed changes are given in the consultation document and draft Contracts, all of which are published on the NHS Standard Contract [2021/22 webpage](#). Only brief details are given below.

A small number of the changes are also applicable to the shorter-form version of the Contract. These changes are identified with asterisks (***)

For each area, please indicate whether a) your organisation supports the proposal, b) your organisation does not support the proposal, or c) the proposal is not applicable to your organisation, and add comments where relevant. Please do not add extra columns or rows to the template, and please return it as a Word document, rather than as a pdf.

The deadline for receipt of responses is Friday 5 February 2021. We will publish the final versions of the generic Contract (both full-length and shorter-form) as soon after that as possible.

2 Your details

Name:	Richard Knight
Organisation:	Association of British Dispensing Opticians (ABDO); Association of Optometrists (AOP); Federation of Ophthalmic and Dispensing Opticians (FODO); Local Optical Committee Support Unit (LOCSU).
Job title:	Head of Policy, LOCSU
Email address:	richardknight@locsus.co.uk

3 Proposed changes

We describe the changes we propose to make to the Contract for 2021/22 in the consultation document and draft Contracts, published on the NHS Standard Contract [2021/22 webpage](#). Only brief details are given below.

3.1 Key changes

Changes to reflect updated national policies

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)	Support proposal?			Comments
			Yes	No	NA	

1	Interface with primary care Service Condition 3.17	We propose to include a new requirement for each provider to publish a self-assessment of its performance against the existing interface with primary care requirements and to agree and implement an action plan to address any deficiencies.	X			We have consistently called for improved engagement between primary and secondary providers, commissioners and all other stakeholders, as well as for greater recognition that primary care extends beyond general practice alone and includes optometry. As such, although the focus of SC3.17 still appears to be predominantly on general practice, we welcome this proposed change to the Standard Contract as it raises the prospects of better secondary care feedback to primary care colleagues which in the optical sector is patchy at best. We also support the proposed requirement for all providers to engage with Local Medical Committees (LMCs). <u>Furthermore, we believe that this should extend to all primary care local representative committees (as relevant to commissioned services), including Local Optical Committees (LOCs).</u> Like LMCs, LOCs comprise of local primary care NHS contractors and professionals with significant experience of service design and commissioner engagement. LRCs should be fully involved with ongoing NHS structural reform. Local Eye Health Networks (LEHNs) which are structurally part of NHS
---	--	--	---	--	--	---

						England Regions should also be part of this clinical engagement.
2	Collaborative work in Integrated Care Systems Service Condition 4.6	The Contract already contains a requirement on commissioners and providers to work together to deliver their local system plan and in support of the NHS's "triple aim" of better health, better care and financial sustainability. We propose to strengthen this by including a specific reference to active participation in, and constructive mutual support and challenge to and from members of, the local Integrated Care System.	X			We support the NHS's 'triple aim,' as well as the Long-Term Plan's objectives of more integrated and preventative health care and the transfer of suitable services from secondary to primary. Given that ICSs are a central part of these reforms, we support contractual measures to enhance their impact. However, it is imperative that Local System Plans through new health bodies (ICSs and PCNs) incorporate a diverse mix of providers and make better use of proven networks of leaders (such as LOCs) than has been the case so far. They must also consider appropriate funding for groups such as LOCs to fulfil clinical leadership and participation roles. This is particularly important in the current climate and given that optical practices deliver many NHS services using the NHS Standard Contract, which are in addition to NHS General Ophthalmic Services (GOS).
3	Remote consultations Service Condition 10.5	We propose to add a requirement for providers to offer patients, wherever clinically appropriate, a choice between a remote consultation and a face-to-face one.	X			This builds on recent eye care service design to offer a balance between remote and physical consultations during the pandemic. However: • Clinical judgement and patient safety must remain paramount in supporting patients to exercise informed choice.

					This must be funded. On balance we suggest the following changes to the proposed wording for SC10.5. NHS England proposed wording: <i>‘The Provider must use all reasonable endeavours to ensure that, in relation to any outpatient or community Service and where clinically appropriate, each Service User is offered the choice between a face-to-face appointment and a telephone or video appointment.’</i> Alternative: <i>‘The Provider and commissioner must work together in a constructive way to ensure that, in relation to any outpatient or Community Service, where clinically appropriate, each Service User is offered the choice between a face-to-face appointment and a telephone or video appointment and that this care is appropriately funded.’</i>
4	Tackling health inequalities Service Conditions 13.9-10 and Schedule 2N	We propose to amend the Contract to require each provider to identify a board-level executive responsible for overseeing the Provider’s actions to address and reduce health inequalities. We also propose to add	X		Although this provision is aimed at Trusts and FTs, nevertheless, we support its inclusion. We would note however that unless commissioning is conducted on a wider and more joined-up footprint than in the past, health inequalities will persist. We

		a new Health Inequalities Action Plan Schedule to the Particulars.				note the proposal for provider health inequalities leads and would urge that these leads, especially in Trusts, are empowered to engage with commissioners and primary care (including eye care providers) to better utilise primary eye care capacity as part of health inequality reduction initiatives. This could save significant and unnecessary capital costs involved with duplicating out of hospital capacity for eye care.
5	Green NHS Service Condition 18 and definitions	We intend to continue to strengthen the requirements in the Contract on green issues by adding requirements on providers to: • identify a board-level officer accountable for actions to deliver on 'Net Zero' commitments; • ensure all electricity purchased is from certified renewable sources; and • implement further measures focused on the reduction of harmful greenhouse gases and air pollution.		X		We are supportive of measures to make the NHS as sustainable as possible by reducing carbon emissions. One way to help achieve this is by transferring suitable services from secondary to primary care as patient journeys to appointments are typically much shorter in primary relative to secondary settings. In addition, primary care optical practices have relatively small carbon footprints as they employ local staff, only require small levels of transport space for stock and often have local or domestic supply chains. We agree that SC18.5 (to switch to renewable sources) should only apply to NHS Trusts/FT. These larger consumers have purchasing power and should be able to offset the impact of price surges when there is a sudden increase in demand for 100% renewables tariffs. Smaller providers

						(non-Trusts/FTs) on the other hand will be able to make this transition when the market evolves further.
6	Infection Control and Prevention Service Condition 21.1	We propose to add a specific requirement that all providers must designate an infection control and prevention lead at Board level.		X		Infection prevention and control (IPC) is the responsibility of all health care providers. We support all realistic and proportional measures to help achieve this. However, in the cases of the optical sector, we already have sector-specific IPC requirements set by the regulators, NHS and professional bodies. These do not require a board level designation (something best suited to large providers—e.g., NHS trusts) as this would not be appropriate (e.g., with small organisations and no ‘operational board’ per se). Commissioners should recognise such proportionality during commissioning discussions, and it would be helpful if guidance could reinforce this.
7	Evidence-based interventions Service Condition 29.28-31 and Definitions	National guidance on a second set of 31 additional interventions has now been endorsed by NHSE/I and published on the Academy of Medical Royal Colleges website. We propose to adapt the Contract wording and definitions to include appropriate reference to this second set of guidance.			X	
8	Safeguarding Service Condition 32.8	We propose to broaden the existing requirement in relation to supporting implementation of the Child Protection	X			

		Information Sharing Project , with this in future applying to all providers (including specifically outpatient and mental health services), rather than just to urgent and emergency acute services as previously.				
9	Freedom To Speak Up General Condition 5.9	We propose to strengthen the Contract wording on “freedom to speak up” by requiring providers to inform the National Guardian’s Office of the identity of its nominated Freedom To Speak Up Guardian(s); and to co-operate with the National Guardian’s Office in any case reviews. ***	X			We have recently been working with the National Guardian’s Office to develop speaking up guidance for primary optical professionals and providers as part of our commitments to patient safety and continuous quality improvement.

Changes to support Primary Care Networks

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)	Support proposal?			Comments
			Yes	No	NA	
10	Enhanced Health in Care Homes Particulars Schedule 2Ai Service Condition 4.10	Contract requirements for Enhanced Health in Care Homes came into effect gradually during 2020/21 – so we now propose to update Schedule 2Ai to remove references to actions which were to have taken place in 2020/21 and to make clear that these are now ongoing requirements for 2021/22. ***			X	Although the majority of care home services performed by primary care professionals are commissioned under GOS, we will monitor any impact this clause may have on extended primary care services commissioned under the Standard Contract.

11	Anticipatory Care Particulars Schedule 2Aii Service Condition 4.9	We propose to include detailed requirements for relevant providers of community physical and mental health services to work with PCNs to implement the Anticipatory Care model. ***			X	
----	---	---	--	--	---	--

Changes relating to people issues

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)	Support proposal?			Comments
			Yes	No	NA	
12	Black, Asian and minority ethnic representation Service Condition 13.7	We propose to require each provider to publish a five-year action plan setting out how it will ensure that the level of black, Asian and minority ethnic representation in its board and senior workforce will reflect that in its overall workforce, or in its local community, whichever is higher.			X	

13	NHS People Plan General Condition 5.1	We propose to amend the Contract wording to make it clear that providers must implement the actions expected of employers as set out in the NHS People Plan.		X		We propose the following changes to the wording of this clause. Currently: <i>5.1 The Provider must apply the Principles of Good Employment Practice (where applicable) and, abide by the staff pledges and responsibilities outlined in the NHS Constitution and implement actions expected of employers as set out in the NHS People Plan.</i> Change to: <i>5.1 The Provider must apply the Principles of Good Employment Practice (where applicable) and, abide by the staff pledges and responsibilities outlined in the NHS Constitution and implement actions expected of employers as set out in the NHS People Plan (where applicable).</i> This is because these policies have been developed in collaboration with NHS owned providers only e.g., NHS Trusts. Part of employment best practice is to engage with your own teams thus optical practices already meet the employer and training requirements of their regulators and professional bodies.
----	---	--	--	---	--	---

14	Core Skills Training Framework General Condition 5.5	We propose to add a requirement to the Contract that a provider must provide its staff with training in accordance with the requirements of the Core Skills Training Framework. ***		X	We propose the following changes to the wording of this clause. Currently: <i>‘each in accordance with Good Practice, the Core Skills Training Framework, and the standards of their relevant professional body, if any, and, in relation to clinical supervision for midwives, A-EQUIP Guidance.’</i> Should be changed to: <i>‘each in accordance with Good Practice, the Core Skills Training Framework (in the case of NHS trusts), and the standards of their relevant professional body, if any, and, in relation to clinical supervision for midwives, A-EQUIP Guidance.’</i> The CSTF is designed for NHS Trusts in England, as evidenced by the link in the NHS Standard Contract to https://skillsforhealth.org.uk/info-hub/core-skills-training-framework-cstf-and-enabling-staff-movement-in-nhs-trusts-in-england/. Proposed wording in the consultation should therefore be changed to reflect this. This will also help avoid duplication, confusing and costs. For example, optical practices already meet employer and
----	---	---	--	---	--

						training requirements of their regulators and professional bodies.
15	Hosting of doctors in training General Condition 5.7	Health Education England will shortly publish new guidance setting out the role of non-NHS providers to work with Trusts in hosting doctors in training. We propose to include a requirement for providers to have regard to this guidance.		X		We await HEE's placement for doctors in training guidance. This GC clause however is not applicable to the wide range of providers to which the Standard Contract applies and so we suggest the wording "where applicable" be inserted.
16	Violence prevention and reduction standard General Condition 5.9	We propose to add a requirement on providers to have regard to the new NHS Violence Prevention and Reduction Standard. ***	X			
17	Workforce sharing General Condition 5.12	NHSE/I have published an Enabling Staff Movement Toolkit, which provides suitable documentation to support workforce sharing between organisations. We propose to add a requirement that, where providers intend to agree workforce-sharing arrangements, they should do using the Toolkit documentation.	X			This appears to relate to clause 5.13 not 5.12. We agree with the principle for these specific circumstances.

3.2 Changes to simplify financial aspects of NHS contracting

Contract sanctions and financial improvement trajectories

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)	Support proposal?			Comments
			Yes	No	NA	

18	Removal of financial sanctions for failure to achieve national standards Schedules 4A, B and C); SC36.37-38; GC9.26	We propose to remove from the Contract nationally set sanctions on providers for failing to achieve national quality and performance standards. This will be more consistent with today's emphasis on collaborative working at Integrated Care System level. ***			X	
19	Reduced frequency of financial reconciliation SC36.28-35; SC28.18-23; GC9.12-25	NHS payment rules under the National Tariff Payment System now place greater emphasis on fixed payments for many providers/services, with much less variation in relation to actual levels of activity in-year. We propose to reduce the frequency of financial reconciliation required under the Contract from monthly to quarterly, thus reducing the administrative burden.***			X	

3.3 Technical improvements and other smaller changes

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)	Support proposal?			Comments
			Yes	No	NA	
20	Counter-fraud arrangements Service Condition 24	The NHS Counter-Fraud Authority (NHSCFA) will be publishing revised counter-fraud requirements in line with the new Government Functional Counter-		X		We support steps taken to reduce fraud and corruption. However, there are already anti-bribery systems in place (as per existing legislation). We cannot support this specific change until we know what the

		Fraud Standard. We propose to amend the Contract provisions accordingly. ***				revised NHSCFA Requirements will be for primary care.
	We also propose to make a number of smaller changes to the Contract, set out under section 3.3 of the consultation paper. If you have any comments on these, please add them in the 'other comments' section below.					

4. System Collaboration and Financial Management Agreement

	Topic	Proposed Change (for full details, please refer to the consultation document and draft Contracts)				Comments
21	System Collaboration and Financial Management Agreement (SCFMA)	The Contract continues to require, at Service Condition 4.9, that CCGs and NHS Trusts / Foundation Trusts will sign, and act in accordance with, an overarching System Collaboration and Financial Management Agreement (SCFMA), setting out how they will work together to deliver system financial balance. A slightly updated model SCFMA, for local adaptation, is published on the NHS Standard Contract 2021/22 webpage. We welcome feedback on the model SCFMA.	X			We support the inclusion of transparency and accountability clauses including financial plans (2.5, 2.6; Schedule 2, Schedule 3). ICSs must not allow themselves to be perceived as opaque or remote, or they will encounter many of the perception problems that hampered STPs. However, while these clauses are welcome, significantly more detail is required. Clarity on where and when such detail will be available is also required. We also support of the requirement to <i>'engage and co-operate with other commissioners and providers of health and care services for the people served by our System (including commissioners and providers of primary care and social care</i>

					<i>services, and including providers within public, private and voluntary sectors'</i> ((2.7, 2.10)). For ICSs to work, this requirement must be met, and ICS leaders ensure that activity which does not represent efficient use of capacity in secondary settings is redeployed to more appropriate primary equivalents. However, we have a significant concern regarding the implications to <i>'consider, and work to improve, the overall efficiency, effectiveness and integration of all of the services we collectively commission and provide for the ICS population, including those specialised and other services commissioned by NHS England'</i> (2.10). In the recent NHSE-I consultation on Integrating Care ABDO, AOP, LOCSU, FODO and other sector bodies made clear our strong view that the national commissioning of GOS must continue. Any changes arising from this consultation must not cut across this. In summary, while we understand the importance of every Trust/FT and CCG signing a SCFMA (as per Technical Guidance) and as a result support SCFMA provisions on accountability, transparency and engagement (while calling for greater detail), we still have concerns about
--	--	--	--	--	--

						potential adverse impacts on patient choice and already efficient models of NHS care.
--	--	--	--	--	--	---

Other comments

NHS England would welcome further suggestions for improving the Contract. Please add any further comments you may have below.

Particulars: Giving each contract a specific contract title and reference is a sensible change.
Model Collaborative Commissioning Agreements Single/Multiple Option: We have no particular comments to make on these documents which, while have been in existence for several years, have not featured often if at all in provider-commissioner discourse in our sector. While these models could become used more as ICSs proliferate, given that they are set at commissioner level, it is the Standard Contract as the contract between commissioners and providers that will remain most pertinent to our members.
Shorter Form Standard Contract: we welcomed the introduction of the Shorter Form Standard Contract for smaller scale services and providers as an attempt to foster greater commissioner understanding of proportionality; regrettably though, it is the Longer Form version that remains commissioners' contract preference. Therefore, our answers and comments in this consultation response reflect the proposed changes to the Longer Form (and indeed by definition any changes to the Shorter Form also appear in the Longer Form).

Consultation responses

The deadline for receipt of responses is Friday 5 February 2021. We will publish the final versions of the generic Contract (both full-length and shorter-form) as soon after that as possible.

Equality and diversity 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:

- reduce health inequalities in access and outcomes of healthcare services
integrate services where this might reduce health inequalities
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

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, Strategy and Innovation Directorate.