Draft NHS Standard Contract 2021/22: A consultation

Stakeholder response document

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2 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.

2.1 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 agree with this amendment in order for services to self-assess and share findings with primary care partners.

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 efforts to facilitate further collaboration at all levels in Integrated Care Systems (ICS). An emphasis on a broader range of goals will assist the government's prevention agenda. Every ICS must involve nursing staff and nursing leaders to set each system goal; and we expect transparent and collaborative monitoring of these targets involving all clinical staff.
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			We support this proposal; however, we are clear that we expect the health and care service to offer all patients access to *both* face-to-face and remote services that reflect their personalised care needs. No patient should suffer as a result of lack of access to technology. Technology education should be a fundamental part of employers' CPD strategies, ensuring all clinical staff have access to the necessary training and equipment.
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			We support this proposal. Inequalities in access to and outcomes of health care services has been a longstanding issue of concern. However, the disproportionate impacts of the COVID-19 pandemic on different population groups have brought

		a new Health Inequalities Action Plan Schedule to the Particulars.				these health inequalities into sharp focus. Health care services have a critical role to play in addressing health inequalities and this will require strategic and comprehensive action. Therefore, we welcome the inclusion of the specific actions relating to health inequalities in the NHS Standard Contract for 2021/22. Ensuring that there is board-level executive leadership in place to oversee the Provider's actions to address and reduce health inequalities will help to drive and coordinate the ambitious and strategic approach needed to drive improvements. Nursing has a vital leadership role to play in addressing and reducing health inequalities, including in treating illness, preventing ill health and promoting health and must be supported and enabled to fulfil this role.
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	X			We support this amendment. We recommend the language is changed to reflect all types of provider services, some of whom may not have a 'Board', or an explanation of language in a glossary that reflects proportionate governance structures.

		• implement further measures focused on the reduction of harmful greenhouse gases and air pollution.				
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			We support this amendment. It is important to note that not all providers have a Board structure and proportionate governance arrangements are outlined in the Health Act, Code of Practice for Infection Prevention and Control. Language should reflect 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			We recommend that language and approach is inclusive. For example; clinician instead of physician, general practice instead of general practitioner. This will reflect the broader ranges of roles who deliver clinical practice and pathways and ensure that staff groups are not excluded.
8	Safeguarding Service Condition 32.8	We propose to broaden the existing requirement in relation to supporting implementation of the Child Protection 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.	X			We support this proposal.

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 support this proposal.

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			When referencing the MDT (multidisciplinary team) we should urge the inclusion of registered nurses who are employed within the care home. Their expertise is substantial. The statement “*base plans on the principles and domains of a comprehensive geriatric assessment (CGA)”* must be made clear that this only applies to care homes providing services to older people. CGA does not have an evidence base for use with people with learning disabilities or younger people.

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			We have concerns regarding the language used as can be confusing to community practitioners who are familiar with the term “Anticipatory Care” within the palliative and end of life care context. We would class this as healthy lifestyle and health promotion advice.

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			We support this amendment. This would be a useful point for the standard contract to introduce and embed intersectional pay gap reporting that as a minimum covers gender, disability and ethnicity. It is important that the pay gap reporting includes a clear requirement for publishing a clear high-quality narrative and action plan that both provides data and insights into the underlying causes of these disparities. This should help support the delivery of the five-year ambition to increase representation of BAME staff at senior levels

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 support this amendment; however, this proposal is only as good as the content of the People Plan. The People Plan released in 2020 contained little in the way of new funding, modelling or workforce initiatives. The final People Plan must contain fully funded strategy based on a population needs based model for future demand.
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 are supportive of this amendment, however there should be a recognition/ reference of clinical supervision relevance to not only midwifery but also nursing.
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	While we do not take a view on the hosting of doctors in training, we do believe that this should include other types of clinical training, for example advanced clinical practice.
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			We are supportive of this amendment; we believe that the language should be further strengthened so that providers are required to implement the new NHS Violence Prevention and Reduction Standard.

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			We support this proposal. We ask that all providers and contractors are required to implement the WRES and Disability standards. They should also commit to pay the real living wage as a minimum.

2.2 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		We do not support this amendment being made in the current context, as delivery against these targets has largely been paused due to the pandemic. As such there is a missing evidence base and opportunity to measure the impact of removing such sanctions and targets. CQUINs and other targets provide incentives for providers to innovate in clinical areas which are often otherwise overlooked. We are concerned that removing these incentives could lead to lack of focus on quality improvement.

						We suggest that there is a separate consultation on this proposal to be conducted once the emergency period is over. This will allow for robust evidence collection and input from wider stakeholder groups, with a view to introducing potential changes in the following year.
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			We support this proposal and believe that it would reduce the administrative burden. Lots of small contracts take a lot of commissioning time. On balance it makes sense to streamline these contracts but there is a risk that some essential all be it low volume activity doesn't get the necessary scrutiny and governance.

2.3 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 are not able to support the introduction of further changes without consultation. We ask that you ensure these standards are made available for consultation ahead of

		Fraud Standard. We propose to amend the Contract provisions accordingly.				them being amended in the NHS Standard Contract.

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.			N/A	

Other comments

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

International staff: We ask that providers are required through the contract to report on number of international staff they have recruited. Providers should also standardise their induction programmes for international staff to ensure that they are not disadvantaged in their work through a lack of robust induction, which will also aid retention. Providers must only recruit from agencies supplying international staff who are approved and adhere to the code of practice for ethical recruitment.
Workforce data reporting: Currently there is disparity between the national reporting of workforce data between independent and NHS providers, and also between the data collected at local level and that which is published nationally. We ask that all providers are required to allow their workforce data to be reported on publicly, not just NHS Trusts. This must include FTE numbers of staff by role and care setting, along with vacancy data. All providers should be required to collect and report on vacant posts, including a breakdown of how many posts are being filled by bank or agency staff. All workforce and vacancy data, for all providers should be made publicly available. We also expect providers to collect, report on and publish data on the '9 safe nursing indicators'[1] in order to generate a better picture of staffing and its impact on patient safety and outcomes. Providers should also be required to produce and publish timely sickness data; currently available data is 4 months delayed. In a pandemic situation this does not allow for robust scrutiny into the impact of the pandemic upon staff members.
Domestic Violence Advisors (supporting the position of the Inter-Collegiate & Agency National DVA (INCADVA) Forum): We note the welcome commitment the Government gave in 2019 on behalf of NHS England to "make Independent Domestic Violence Advisors (IDVAs) integral to every NHS Trust Domestic Violence and Abuse Action Plan, as part of the NHS Standard Contract". We also note that the deadline for this appearing in the NHS Contract was April 2020. We would like to see the NHS strengthen its existing safeguarding duties to adult and child victims of domestic abuse by revising Section 32. In particular we would like to see commitments made to ensure the Contract aligns with NICE DVA Standards published in 2016[2]:

[1] https://www.nice.org.uk/guidance/sg1/chapter/9-Safe-nursing-indicators
[2] https://www.nice.org.uk/guidance/qs116

- Ensure patients are asked about their experiences of DA by Level 1 or 2 trained staff in line with NICE standards - Ensure that all patients disclosing experience of DA are referred to a co-located Idva-based service. - Ensure the Trust has a Domestic Abuse policy which covers both patients and staff, which is regularly reviewed and monitored by the Board. - Provide data on domestic abuse disclosures, number of domestic abuse referrals and the referral route to support, as well as outcome data for patients who have received Idva services.
Car parking All providers should be required to provide free and secure car parking facilities for staff members. Employers should ensure that this covers all shifts and working patterns. For community-based staff, agreements must be in place with Local Authorities to provide parking exemption for the nursing & midwifery workforce.

Addition to Consultation – January 2021

NHS England and GPC England have now agreed a position on the way in which a Primary Care Network (PCN) will, in future, be supported by at least one WTE registered mental health practitioner, employed by a secondary care provider but embedded as part of the PCN's core multi-disciplinary team. We have updated Schedule 2Aiii (Primary and Community Mental Health Services) of the full length Particulars accordingly, and they are republished here. This change is likely to be of interest to mental health commissioners and to mental health trusts only.

RCN response

We broadly welcome this proposal and the increased interest and commitment to develop mental health care in primary care settings.

However, we do not support the proposal for a band 5 practitioner to lead the delivery of mental healthcare across a PCN as outlined, we would expect the minimum grade of the mental health practitioner to be at band 6 or equivalent due to the responsibilities and scope of practice (*combined consultation, advice, triage and liaison function*).

With the emerging and developing advanced practice workforce (ACP/ANP) there is an opportunity for mental health practitioners to have a lasting impact with PCNs. Advanced level mental health nurses have developed their skills and knowledge through the

four pillars of advanced practice (clinical, leadership, education, and research) – studying at masters level. Advanced practitioners are typically at band 8a (7 in some settings).

There is an opportunity for advanced practice mental health nurses to have a lasting impact within and across the PCN. Not only would these roles provide patients with an advanced level of clinical care (including physical health), their skills in leadership, research and education could be utilised to develop the wider primary care workforce, while evaluating and improving the quality of services.

The RCN will soon be publishing a case study of an Advanced Practice Mental Health Nurse who is practicing within a PCN – this will provide a valuable insight into the positive impact these roles can have on the multi-disciplinary team and local populations.