

NHS Standard Contracts – Frequently Asked Questions

	Question/ comment	DH response
1.	Is it intended that the standard mental health contract is used only for contracts with NHS Mental Health Trusts or for all providers of mental health services?	The contract should be used for all NHS commissioned services provided by NHS, private and 3 rd sector providers.
2.	Are there any areas of service where the NHS standard contract will not apply?	The standard contract will not apply to GMS and APMS services. For example, if one individual is supplying a counselling service to a GP practice, the standard NHS contract would not be appropriate as the counsellor is not being commissioned by the PCT Where the service is being supplied to the PCT, then the standard NHS contract should be used.
3.	Which services are intended to be included in the mental health contract?	The mental health contract should include mental health services for adults of working age and older adults, children, substance misuse services and learning disability services. For community LD services provided by a PCT, it would be possible to include the community LD service within the community contract (but not any specialist mental health element).
4.	Will DAT funding be included in the contract?	Yes where this is controlled by NHS commissioners, but commissioners should ensure that there is clarity about funding streams.
5.	Should the contract be used for small scale providers of mental health services eg £20-£40k contract value.	There will be some circumstances in which it may be more appropriate to use a grant. The National Audit Office decision support tool 'Financial relationships with third sector organisations' provides guidance on appropriate use of funding streams.
6.	How can commissioners support 3 rd sector	It may be possible to support these organisations using

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	organisations to implement the standard contract?	networks or umbrella organisations. In one SHA area, a PCT provided facilitated sessions for 3 rd sector providers to support their understanding of the contract.
7.	Will commissioners need to use two different contracts for acute providers who provide community services?	This depends on the circumstances. It would be possible to insert a new service specification into an existing acute contract. However, in this case, it is important to ensure that any relevant contract clauses were included. For example, the community contract contains less stringent conditions re 18 week targets and clostridium difficile. Therefore, in some cases it might be more appropriate to use both contracts, or to ensure the relevant standards are included in the service specification.
8.	What is the legal status of the contract between the commissioning and providing arms of a PCT?	The contract is not legally binding between the commissioning and providing arms of a PCT, as they are not two separate legal entities.
9.	Can commissioners use the commissioning process to favour one provider?	No. Advice on procurement are contained in the PCT Procurement Guide. The PCT will need to also have regard to the Rules on Cooperation and Competition
10.	Is it mandatory to use the contract for provider to provider contracts?	The standard contract is to be used for PCT commissioned services. Provider to Provider contracts will need to have separate contracting arrangements to ensure that there is clarity of responsibility between the two provider parties
11.	Where a community provider is providing acute services, can they use the acute tariff?	Yes.
12.	Where the lead commissioner is a local authority (eg for learning disability services), should there be a separate contract with the local authority?	There is no obligation for local authorities to sign up to the standard NHS contract. Where a provider has a lead NHS commissioner for one service and a lead local authority for

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		other services, it may be necessary to sign up to separate contracts, regardless of whether the local authority signs up to the NHS standard contract.
13.	Should commissioners use the standard contract for spot purchasing? What happens if a resident of one PCT turns up in another part of the country as an emergency admission?	The standard contract can be used for spot purchasing. It may be helpful to agree individual service specifications for individual high cost low volume service users. If the provider is one you use regularly, you may wish to attach a value or the contract could be zero based. It might also be possible to join as an associate commissioner with an existing group of commissioners.
14.	We have a contract with a nursing home outside the SHA area for 4 beds. How will this arrangement work under the new contract?	You could contract separately with the nursing home or alternatively join in with the commissioners of the relevant SHA as an associate commissioner.
15.	Will there be a central mandate to move towards a cost and volume contract.	There is currently no central mandate but there are incentives in the contract to move away from block contracts eg non-payment for non-commissioned activity.
16.	Is the DH intending to develop a subcontract template?	No but providers may find it helpful to consider using relevant clauses from the main standard contract.
17.	We have just agreed a three year contract with the PCT. Will this have to be re-visited?	No, apart from where notice has been given, all legally binding contracts should be honoured.
18.	Is there any opportunity to vary the length of the contract from the standard 3 years.	Any change to a 3 year contract duration would need to be agreed by the SHA. The maximum term of the contract is 3 years,
19.	We are undertaking a service review and do not want to be committed to a service for the full 3 year period. What is the position under the new contract?	You should discuss any potential changes that you are aware may take place during the contract period with a provider as soon as possible. A planned service review could be written into the contract documentation, allowing for potential

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		changes to take place during the term of the contract.
20.	Quality is reliant on the availability of reliable information. Can you withhold funding if this is not available?	<p>Providers of MH and Community Services are required to agree a data quality improvement plan with their commissioners (clause 29) to dates to agree improvements. If the provider breaches the agreed plan , the commissioner may withhold 10% of the monthly contract value until the breach is resolved.</p> <p>The contract also introduces a monthly clinical quality review (clause 33). A commissioner can request a joint clinical investigation, if the provider fails to meet a clinical quality performance indicator. The joint clinical investigation may result in a remedial clinical action plan being agreed. If the provider fails to implement the remedial clinical action plan, the commissioner may take the action agreed in the Schedule 3 Part 4a.</p>
21.	Will there be guidance on the use of CQUIN and PROMS in the contract.	<p>It is understood that CQUIN will not be mandated for 2009 for Community, Mental Health and Ambulance services but providers are encouraged to agree locally based quality improvement initiatives</p> <p>PROMS is mandated for the Acute Services as set out in the guidance issued by the DH</p>
22.	How do Health Care Commission and Monitor standards fit in with the quality standards?	The quality and other standards in the contracts are agreed with the PCT commissioners. The standards from Health Care Commission and Monitor are separate however PCTs need to be mindful of the potential for double jeopardy

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23.	Should a local authority take the lead where there are joint funded arrangements?	This will depend on individual circumstances and the agreements in place between the PCT and local authority.
24.	How will the co-ordinated commissioner arrangements work where we have contracts in different SHA areas?	It would be possible to become an associate commissioner under arrangements in a different SHA area.
25.	How have local authorities been involved in the development of the NHS standard contracts?	Local authorities have been involved at a national level through membership of a representative from the Association of Directors of Adult Social Services (ADASS) on the contract reference groups. It is important to engage local authority colleagues at a local level.
26.	Does the contract contain provisions for an annual review of costs/ inflation?	Yes. These are for local negotiation.
27.	How do we deal with consultant to consultant referrals (eg in a situation where there are no beds available locally)?	You should agree a prior approval scheme with your provider and include this in the contract.
28.	When do we use the termination and variation clauses?	The termination allows for cessation of part or all of the service, by giving 12 months notice after commencement of the contract. Variation to a service is subject to notice periods in the Variation procedure. In general notice periods are maximum notice periods and can be reduced, with agreement of both parties.
29.	Will the obligation to use CEDR in the event of a dispute apply to non foundation trusts?	No, CEDR process does not cover NHS Trusts. The SHA will resolve disputes between NHS Trusts and Commissioners.
30.	Why can't we fine providers if they miss a target, without giving them an opportunity to remedy the breach?	The contract is built on the basis of remedy before penalty. As good practice contracts usually include an opportunity to remedy a contractual breach, before a penalty is levied.
31.	Given that CQUIN will not be mandatory for	You can use the variation process, with the agreement of both

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	mental health and community services for the first year of the contract, how do we mandate something half way through the contract period?	parties. The mandatory introduction of CQUIN would also come within the definition of the Law, which providers are obliged to implement.
32.	Would the Section 75 agreement override the NHS standard contract?	No but it is advisable to ensure that any obligations under the NHS standard contract are also included in the Section 75 agreement eg quality and performance standards).
33.	Will the DH be issuing standard service specifications?	The service specifications will need to reflect local services..
34.	Why aren't child protection issues included in the contract?	Wording for a clause covering child and vulnerable adult protection issues is being agreed and will be included in the final contract documentation.
35.	What should we prioritise in rolling out the new contract?	A number of organisations have identified service specifications, quality indicators, activity planning and prices. As their key areas.
36.	At what stage should you start working on the service specifications?	This is one of the areas you can start work on now.
37.	Will SUS be the standard reporting mechanism for community and mental health providers?	Yes
38.	How will personalised budgets affect the contract?	Personalised budgets will not fall within the contract, although the move to such budgets may affect existing provider contracts. In this case, any move should be flagged up within the contract. It is important to consider the support a service user may need when spending their personalised budget.