



The deadline for receipt of responses is 26 January 2024. We will publish the final versions of the generic Contract (both full-length and shorter-form) as soon after that as possible.

Core requirements to safeguard quality of care

		Support proposal?			Comments
		Yes	No	NA	
6)	Care Quality Commission (CQC) "quality statements"	X			From the consultation and draft Standard Contract Technical Guidance it appears the goal is for all providers with an NHS Standard Contract (even those that do not perform CQC regulated activities and are not regulated by the CQC) to have regard for the CQC quality statement domains: • Safe (with eight sub domains) • Effective (with six sub domains) • Caring (with five sub domains) • Responsible (with seven sub domains) • Well-led (with eight sub domains) These domains are already common in primary eye care and primary care audiology, so we support this proposal in principle. However, the CQC guidance on its quality statements is very prescriptive

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					and written for CQC regulated providers. On balance it would be helpful if the NHS Standard Contract Technical Guidance could make it clear that non-CQC regulated providers will have systems and controls in place which will mirror these CQC domains.
7)	Fit and Proper Person Test for board members of NHS bodies	X			
8)	Supervision of the management of services by non-NHS providers	X			
9)	NHS Complaint Standards		X		Primary eye care providers, under General Ophthalmic Services regulations, are required to comply with complaints procedures. It would be impractical for providers to have to comply with different standards for different contracts (ie one for the national GOS contract and another for local enhanced services under the NHS standard contract). If the standards for both contracts align, then we have no issue with this proposal. Where providers undertaking a local enhanced service already hold a GOS contract (and are therefore already subject to NHS complaints procedural requirements) they should not be subject to additional requirements under the NHS standard contract.

National access and waiting times standards

		Support proposal?			Comments
		Yes	No	NA	
10)	Cancer waiting times	X			

Service provision – new additions to reflect national priorities

		Support proposal?			Comments
		Yes	No	NA	
11)	Diagnostic imaging reporting turnaround times	X			
12)	Patient and Carer Race Equality Framework	X			

Service provision – areas where updated Contract wording is needed

		Support proposal?			Comments
		Yes	No	NA	
13)	Maternity and neonatal services			X	
14)	Fit notes			X	
15)	Antibiotic usage			X	
16)	Emergency Preparedness, Resilience and Response (EPRR)			X	

Patient safety

17)	Patient Safety Incident Response Framework (PSIRF)		X		NHS England has stated that further exploration was required to ensure successful implementation of the PSIRF within primary care. We do not believe this has been undertaken and a consultation on this point has not been released. The NHS standard contract says PSIRF applies to all services under the Standard Contract. The PSIRF guidance states that it is not a requirement for primary care providers under the standard contract, but they may wish to adopt it. We assume this is not changing and therefore primary care providers are not subject to PSIRF but will have their own incident response procedures in place, some adopting the PSIRF.
18)	Learn From Patient Safety Events Service	X			
19)	Patient Safety Specialists	X			

Workforce

		Support proposal?			Comments
		Yes	No	NA	
20)	NHS Equality, Diversity, and Inclusion Improvement Plan	X			
21)	Mandatory staff training on learning disability and autism	X			While we agree with the proposal to increase awareness of learning disabilities and autism, this additional requirement will incur significant additional financial costs for providers – through provision of the training and in staff time to attend the training. This cost should be borne by the ICS and not the provider or worker.
22)	NHS Long Term Workforce Plan	X			

Procurement of good and services

		Support proposal?			Comments
		Yes	No	NA	
23)	Procurement frameworks for goods and services	X			Our response is based on SC39.1 which states this only applies to NHS Trusts and Foundation Trusts. Primary care providers that provide enhanced services under the NHS Standard Contract are paid a fixed rate for services and cannot run a state funded deficit, so they already have strong incentives to manage their supply chains efficiently. We therefore agree SC39.1 should be restricted to NHS Trusts and Foundation Trusts.
24)	Nationally Contracted Products Programme / NHS Core List	X			See our response to Q23
25)	Agency rules	X			See our response to Q23
26)	Duty to explain purchasing decisions	X			See our response to Q23

Impact of the new NHS Provider Selection Regime

		Support proposal?			Comments
		Yes	No	NA	
27)	Permitted Variations	X			See our response to Q29.
28)	Termination	X			See our response to Q29.
29)	Recording of route through which contract was awarded	X			We support this proposal. In our view it would be helpful for the PSR, patient choice, pricing and NHS Standard Contract leads at NHS England to work together to support ICBs with additional guidance here to ensure that patients, the NHS and taxpayers benefit from the PSR. For example, many commissioners did not comply with the NHS Procurement, Patient Choice and Competition Regulations 2013 (PPCCR) and have rolled that non-compliance into the new PSR. This can be at a significant cost to patients, the NHS and taxpayers. This is an opportunity to address those legacy issues and help reduce excessive waiting lists which cost patients and the wider economy dearly. In cases where patients are experiencing undue delays in accessing services or the NHS is paying more than it needs to pay, for example audiology where patient choice has not been implemented, it is important that the PSR is used as an opportunity to address legacy issues. Here NHS England might ask ICBs to prioritise transitioning non-compliant PPCCR procurements to a review under the PSR, in particular ensuring that services comply with the PSR key criteria [1]. [1] https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/#key-criteria

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30)	Extension of contract term	X			See our response to Q29.
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Patient choice of provider

		Support proposal?			Comments
		Yes	No	NA	
31)	Patient choice legislation and guidance	X			
32)	Acceptance of referrals	X			
33)	Variations for new "choice" services / locations	X			In the past, despite the NHS saving significant cost per patient through primary care audiology sites, commissioners in some regions blocked new choice locations. We think providers are best placed to understand how their patients prefer to access services. Providers can determine if they are willing to invest new capital to move services or add capacity to manage local needs, while the NHS pays the same per patient or less. This strategy would therefore align with the PSR key criteria and benefit patients, the NHS and taxpayers. It would equally be helpful to audiology services in this context as currently these services have unsustainable waiting list pressures in secondary care. These pressures can be addressed through simple compliance with the PSR key criteria and correct use of the NHS Standard Contract.

Contract management processes

		Support proposal?			Comments
		Yes	No	NA	
34)	Withholding of funding for Information Breaches	X			We support removing this from SC28.18-25 and managing any issues under GC9.
35)	Activity management	X			In the past, commissioners have used activity management as a blunt tool. For example, restricting patient choice and access to try and control total cost while letting opaque and inefficient block contracts run alongside more efficient and transparent contracts, all while basing activity assumptions on historical activity data rather than a local JSNA. In this context we think the proposed approach, along with helpful clarity in the Technical Guidance how not to use activity management plans, is helpful and should support ICBs make more strategic commissioning decisions. However, in our view, more guidance could be given on Indicative Activity Plans (IAPs). For example, with hearing needs, ICBs should be mindful of local JSNAs which should set out local need. If JSNAs do not have this data then ICBs should be very sceptical about their IAP assumptions. For instance, it would be prudent in these cases for ICBs/ICPs to engage public health leads to provide a reliable estimate of local needs and use this to set more realistic IAPs. Using good data rather than historical assumptions will then help all providers and commissioners work in a more collaborative way. Specifically to focus discussions on how to meet need in an affordable and sustainable way, as opposed to commissioners using IAPs to reduce patient access through workarounds and storing up bigger problems for the future. We believe this is also an opportunity to explain the NHS Standard Contract as one of many tools available to ICBs to deliver the NHS Long Term Plan goals, especially with regard to prevention and

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					supporting people to age well and transforming outpatient care. We would be happy to share examples and economic data with NHS England's Standard Contract, pricing, PSR, diagnostic transformation and patient choice teams if this would be helpful.
36)	Prior Approval Schemes	X			Provided the specific scheme is evidence based and has been put in place after appropriate and proportionate consultation we would support this.
37)	Invoice payment files			X	It appears Trust will benefit from a "less burdensome approach". We hope that this will also free up time to ensure non-NHS providers, who will have to submit invoices as now, are paid on time.
38)	Audit		X		During consultations on the PSR, stakeholders raised concerns about a lack of transparency and challenge in the system. In that context, we think it is important to maintain the option of checks and balances in the Standard Contract so tools exist to manage provider incentives/behaviour. In this context, while we understand why GC15.8-13 should be simplified/cut down, we think more needs to be done to ensure sufficient safeguards remain in place to allow commissioners to audit a provider if they wish to rule out concerns about up-coding or other risks of local distortions in resource allocation. We would therefore support leaving in 15.8.2. Other deleted provisions can be managed via other conditions in the Standard Contract – e.g. there are already provisions to manage quality and providers already have other proportionate requirements with respect to financial controls etc.

Further comments

39)	• Para 15.1, 15.3, 25.19, 25.20 and other sections in the Technical Guidance refer to the PSR as still being subject to “parliamentary approval” etc. This text can be simplified now the PSR is in force. • Para 15.4 Technical Guidance. This refers to “competitive process”, it might be helpful to use PSR terminology– e.g. providers commissioned under direct award process B should have the same version of the Contract for that specific service etc. • Para 19.3 Technical Guidance. It would be helpful to add “Commissioners should also consider Key criteria in PSR guidance to ensure services continue to serve patients best interests - see para 19.6”. • We welcome the additional detail on medical malpractice insurance as this is an area that is not as well understood. However, we are not sure how or why ICBs should have to spend, what are likely to be significant sums, on “a reputable insurance broker” (para 47.51). It might be helpful instead for ICBs to be given training on medical malpractice insurance so they understand the difference between claims made and claims occurring, a contract of insurance vs discretionary schemes in the context of UK regulation etc. This can be done once centrally as opposed to spending significant scarce NHS resources on broker fees. Providers should also be able to provide ICBs with the necessary details, and providers can obtain the information they require from their own FCA authorised supplier (under the Consumer Duty) etc. If it would be helpful to the NHS Standard Contract team, as a provider of medical malpractice insurance, we would be happy to explain our experience in this insurance market, including about conflicts of interests in the supply chain, significant differences across health specialities as well as some common principles. • Changes to payment processes, e.g. SC36.22 and 36.31. With system pressures, inflation and high interest rates, smaller providers can no longer afford to absorb the impacts of delayed NHS commissioner payments. We hope that by putting in a different system for NHS bodies, there will now be more capacity to speed up the processing of payments for primary care-based providers delivering enhanced services. • We fully support SC36.32, i.e. interest being applied to late payments. Even under the old CCG structure however this was seldom used as commissioners leveraged the monopsony power to avoid challenge. Under new more powerful ICB monopsonies there is a concern that providers, even those struggling, will want to challenge for interest payments for fear of confrontation and unfair treatment by commissioners. It would therefore be helpful if NHS England Technical Guidance might make clear that if a provider requests interest under SC36.32 they should not be discriminated against.
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