Guidance on the NHS Standard Contract for Care Home Services 2011/12

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Guidance on the NHS Standard Contract for Care Home Services 2011/12

Contents

Executive summary

This guidance document provides support to commissioners and providers in implementing the 2011/12 NHS Standard Contract for Care Home services.

The care homes contract is a one-year interim contract to be used when contracting for NHS funded care home services. The guidance sets out how the contract should be used and provides explanation on some of the key elements of the contract.

1 Introduction

1.1 This is the first year that an NHS standard contract for care homes has been published. Its publication was in response to requests from care home representative organisations commissioners and providers for a bespoke contract for care home services, given the differences between care home services and other NHS funded care delivered in hospital and community settings.

1.2 The Department of Health has worked with provider and commissioner stakeholders in developing the 2011/12 care homes contract.

1.3 The contract is one of the suite of NHS standard contracts covering:

- Acute hospital services
- Ambulance services including patient transport
- Community services
- Mental health and learning disability services

1.4 As a bespoke contract, the development of the care homes contract has been guided by two principles:

- Quality improvement is at the heart of the standard contracts. The contracts are the means by which commissioners encourage and reward the provision of good quality services for their local populations.

- The established principle is to have a standard form of contract for use across all NHS funded services covering all types of provider and all types of services with deviations from this only where such deviation is necessary to reflect the type of care being provided.

1.5 The contract is published as a one-year interim contract. This will allow for further evolution of the contract in subsequent years.

1.6 This guidance document is intended to support commissioners and providers in implementing the contract and should not be viewed as an interpretation of the contract. In the event of conflict between this guidance document and the contract, the terms of the contract will prevail.

1.7 Additional guidance on the use of NHS standard contracts is available in the 2011/12 Annex to the 2010/11 Standard NHS Contracts Guidance http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124324

1.8 The Association of Chief Executives of Voluntary Organisations (ACEVO) also published guidance on the NHS Standard Contracts for community services and mental health & learning disability services in 2010 which provides a short overview of each of the two contracts.
www.acevo.org.uk/Document.Doc?id=515
www.acevo.org.uk/Document.Doc?id=516

2 Aims and principles

Principles

2.1 The standard contract provides a framework to hold providers to account for the delivery of high quality services to NHS funded service users.

2.2 During the development of the original suite of standard contracts, the members of the Contract Stakeholder Reference Group agreed a set of behaviours that should be expected of providers and commissioners in their contractual relationship. These are of equal relevance to relationships with the care homes sector.

2.3 The parties should:

- Find and support win-win solutions
- Achieve appropriate risk sharing, and sharing of any benefits that are realised by mutual effort
- Maintain mature, regular dialogue within a professional code of conduct
- Ensure flexibility where there are genuine problems in delivery
- Provide incentives as well as penalties
- Maintain honesty and transparency – across both parties and with Service Users and the public.

Behaviours

2.4 Commissioners and providers will be expected to behave in accordance with the Principles and Rules for Co-operation and Competition. Any SHA-led commissioning 'rules' or requirements must also be consistent with these principles and rules.

2.5 Commissioners or, where applicable, co-ordinating commissioners, will be required to work with providers to ensure they meet the quality requirements set out in the contracts. The quality requirements are over and above the requirements set out by the Care Quality Commission and other regulators.

3 When to use the care homes contract

3.1 The care homes contract is available for use when contracting for NHS funded care home services. The contract can be used with all types of care homes, including those providing care for older people, people with mental health problems and people with physical disabilities.

3.2 Continuing healthcare services provided by NHS Trusts and Foundation Trusts would usually be part of a wider portfolio of their contracted services and therefore this care homes contract should only be used when contracting for care home services from the independent and voluntary and charitable sectors.

3.3 The contract does not cover Free Nursing Care payments- appropriate locally agreed arrangements should be used for these.

3.4 Where a care home provides additional NHS funded services eg outreach services, then the relevant community or mental health and learning disability contract should be used.

3.5 Where commissioners decide not to use the care homes contract the community or mental health and learning disability services contact should be used.

3.6 Where care home services are jointly commissioned with a local authority, the local authority may wish to consider using the care home contract for its placements.

3.7 Bilateral and multi lateral versions of the contract are available, depending on whether one or more commissioners enter into a contract with a care home provider.

3.8 In procuring care home services, commissioners should have regard to the PCT Procurement Guide and the Principles and Rules for Co-operation and Competition when procuring care home services.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

4 The structure of the NHS standard contract for care home services 2011/12

4.1 The contract is divided into four sections:

- Module A (The Particulars): a short contract document setting out the parties to the contract and key dates. This should be completed by the parties and signed

- Module B: contains the main sections relating to the Services being commissioned, including the service specification, quality and information requirements. These require commissioner and provider input. This section should be agreed and completed by the parties prior to signing the Particulars.

- Module C (clause 1 to 57 and Schedule 1): these are the standard terms and conditions of doing business with the NHS. This section contains the main legal clauses and Schedule 1 (Definitions). This section cannot be amended or changed and is only available in PDF format.

- Module D (schedules 2-17) Some of these Schedules require commissioner and provider input to make the contract executable. This section should be agreed and completed by the parties prior to signing the Particulars.

4.2 The Particulars (Module A) include a number of key dates:

- **Effective Date**: the date it is signed by both Parties
- **Anticipated Service Commencement Date**: the date on which the parties expect the service to commence
- **Longstop Date**: the date by which the services must commence for the Agreement to proceed
- **Delayed Service Commencement Date**: the actual date the service commences if this is later than the Anticipated Service Commencement Date
- **Service Commencement Date**: the actual date the service commences

These dates should be inserted as appropriate, as indicated in Module A.

Duration

4.3 The contract has a twelve-month duration unless authorisation has been obtained from the relevant SHA/ DH for a longer term. The one-year term contract should expire no later than 31 March 2013.

4.4 It is recommended that once the contract is agreed, the whole contract (Particulars, Standard Terms and Conditions and Schedules) is printed off and signed. The document should also be kept electronically to ensure good governance and to assist transition of the contract to the GP Consortia.

4.5 The contract is colour coded. The ‘red’ elements are mandated elements which cannot be changed, ‘amber’ highlighted elements are mandated for completion by the

commissioner and provider through negotiation and are required for an executable contract. The 'green' highlighted elements are optional and may be inserted following local agreement. The 'green' elements are not required for an executable contract but should be completed prior to signing the contract.

4.6 It is important to note that the Standard Terms and Conditions must not be changed and are therefore available only as a PDF file. Relevant text within Modules A, B and D coloured amber and green can be edited into the document and then only to the extent indicated in the text.

5 Completing Module B

Service specifications (Section 1 Part 1)

5.1 The service specification can be found in Module B Section 1 Part 1.

5.2 Some of the headings in the template are mandatory. These are identified in amber on the contract schedule. Use of other headings, and all the subheadings, is optional. This means that the specification can be adapted for local requirements.

5.3 The level of detail within the service specification should be appropriate to local circumstances. However, the specification is not intended to replicate operational policies. It should give clarity to both commissioners and providers on how the service will be provided and the outcomes expected from the service.

5.4 Section 4.3 of this service specification provides the opportunity to identify arrangements for the provision of bespoke equipment for individual service users and any equipment which is specifically not covered by this contract.

5.5 Section 5 (Individual Service User Placements) should be used to set out details of individual placements for cost per case contracts and the relevant prices for each placement.

5.6 One service specification can be used to specify the entire service commissioned. A separate service specification may also be used for each placement, where this appropriate.

5.7 Section 6 of the service specification contains a space for quality requirements to be set out. The completion of this section is optional. Where it is used, the same information must be included in Section 3 Part 1 of Module B (Quality Requirements).

Activity and Annual Contract Value (Section 2)

5.8 Activity Plans relating to block contracts should be set out in this section.

5.9 The Annual Contract Value may consist of one or more types of contract (ie block, cost per case or cost and volume. Details, including prices and any expected annual cost should be set out in the table in Section 2 Part 2

Quality Requirements and Never Events (Section 3)

5.10 There are two parts to this section:

Part 1: Quality Requirements. There are no mandated national requirements. Therefore, all requirements should be agreed locally. In considering appropriate quality requirements, commissioners should avoid duplication with CQC requirements and should ensure that the number of identified requirements is proportionate to the size of

the contract. The resource implications of data collection and analysis should be considered.

The Parties may agree locally defined consequences to breaches of quality requirements included in Part 1. Where there are locally defined consequences, clause 29.1 of Module C will apply. It is not mandatory to include a locally defined consequence of the breach for Part 1 requirements. Where breaches occur, the commissioner may use the contract management process outlined in clause 29.

Part 2: Never Events. These are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.The Never Events outlines in the contract are a nationally mandated list. The table includes all Never Events which could occur in a care home setting. Not all Never Events could occur in every type of care home and the Never Events listed apply only to those services to which they are relevant. However, the table should not be amended. National guidance on Never Events is available and should be followed in determining the level of any consequence.

(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124552)

The Service Development and Improvement Plan (Section 4)

5.11 A Service Development and Improvement Plan (SDIP) should be agreed prior to signing of the contract. The plan should set out any improvements to be made by the provider to the Services and / or the Services Environment. The size of the Plan should be in alignment with the size of the contract.

5.12 The Plans are intended to complement, rather than repeat, other sections of the contract. The SDIP is not intended to duplicate any agreed CQUIN goals.

5.13 The plan should be agreed prior to the contract Effective Date and should be appended in the appropriate schedule. Progress against the plan should be reviewed through the contract review process (clause 8) and any issues addressed through the contract management process (clause 29). Where both parties agree changes, these should be recorded as a contract variation in the relevant schedule and the plan updated as appropriate.

5.14 In developing the SDIP, the Parties should take account of the guidance on the behaviours to be expected of providers and commissioners in their contractual relationship which are outlined in Chapter 2 of this document.

Incentive Schemes (Section 5): Commissioning for Quality and Innovation (CQUIN) payment framework

5.15 Agreeing a CQUIN scheme is a requirement of the NHS Standard Contract. Guidance on using the CQUIN framework can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

5.16 Section 5 Part 2 sets out how the CQUIN payment framework operates and includes a table where the agreed scheme should be inserted.

5.17 One CQUIN scheme should be agreed for each care home. It is suggested that the main local NHS commissioner takes responsibility for agreeing a scheme with the care home, and that this scheme is then included within any other NHS contracts held by that same care home.

5.18 Examples of agreed CQUIN schemes and a set of Frequently Asked Questions (including on joint commissioning) can be found at:

http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

5.19 Some of the indicators used within community and mental health schemes may be particularly relevant for consideration by care homes.

5.20 As stated within published guidance, “there is a strong argument for keeping schemes simple” (paragraph 28) and for a small organisation it may be appropriate for the scheme to comprise one or two quality improvement goals, with a single payment for achievement.

5.21 Local organisations may wish to align CQUIN goals with aspects of the Care Quality Commission’s excellence rating system (soon out to consultation), enabling providers to use achievement of locally agreed CQUIN goals as evidence for the CQC assessment process. CQUIN payments should not however be linked to resolution of major concerns identified by CQC in relation to essential standards. The CQUIN framework is intended to reward ambitious quality improvement and excellence over and above minimum standards.

Information Requirements (Section 6)

5.22 The Information Schedule lists the reports that are required on a regular basis.

Part 1 sets out the requirement to comply with any national requirements which are reported centrally.

Part 2 lists the national requirements which are to be reported through local systems. Many of these relate to reports mandated within the contract eg the provision of a regular service quality performance report.

Part 3 is where any locally agreed requirements to be reported locally should be inserted

Part 4 provides a pro forma table for the Data Quality Improvement Plan

The Data Quality Improvement Plan (DQIP)

5.23 The DQIP allows the commissioners and the providers to agree a local plan to improve the capture and flow of data both to support the commissioning and contract management processes.

5.24 The plan is non-mandatory but can be used where the parties to the contract wish to achieve improvements in the completeness and accuracy of data or wish to collect new information items where it may take some time for before accurate or timely information can be provided.

5.25 Using the data quality improvement plan means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under clause 27 (Information Requirements) only if the requirements of the data quality improvement plan are not achieved.

6 Providing information

6.1 This chapter sets out how information should be provided under the contract and how providers may connect their information systems to NHS England centrally managed systems and services, where this is appropriate

Clause 27 (Information Requirements)

6.2 Clause 27 describes the requirements placed on the provider to supply the information which is detailed in Module B part 6 (see chapter 5). Figure 1 sets out the process for the provision of information.

6.3 The gathering of regular information facilitates the monitoring of progress against agreed outcomes, provides clarity of the activity undertaken and highlights performance against any agreed target. The Contract requires the Provider to submit all specified information in a timely manner, for an agreed period, ensuring accuracy and completeness at all times.

Centrally managed systems and services

6.4 Currently there are no centrally required information reporting requirements for care home services. However, if this were to change in the future, providers would be required to provide the relevant data items through centrally managed services with support available from the NHS Business Partner Programme

6.5 The NHS Business Partner programme, managed by NHS Connecting for Health, provides support and guidance to contracted providers and their IT suppliers on integration to NHS centrally managed services. A mini guide is available to new providers to help them understand the IT requirements. For further information and to gain a copy of the mini guide please contact businesspartners@nhs.net or visit www.connectingforhealth.nhs.uk/systemsandservices/businesspartners

Safeguarding information

6.6 The contract requires care home providers to have safeguards in place to protect information. Clause 25 (Data Protection, Freedom of Information and Transparency) sets out the requirements around safeguarding data, as well as the support providers are expected to give commissioners in responding to Freedom of Information requests.

6.7 **Information Governance (IG)** ensures the necessary safeguards and appropriate use of patient/service user information. The Information Governance Toolkit (IGT) enables providers to assess themselves against the Department of Health Information Governance policies and procedures. Compliance against the toolkit is a requirement of the Contract and Care Home Providers will need to complete an IGT for their organisation. The IGT covers the following areas; IG Management, Confidentiality/Data Protection, Security and Clinical Information Assurance. Some Providers may find the requirements in the IGT difficult to complete and some may not seem relevant to them. Support is available from the IGT team via the Exeter helpdesk (exeter.helpdesk@nhs.net). Further information on IGT requirements can be found www.igt.connectingforhealth.nhs.uk

Mandatory requirements relating to information

6.8 The following are the key information requirements relating to care home services

Organisation Data Services (ODS) Codes are unique codes allocated to all organisations providing NHS funded care. These codes form part of the NHS data standards and have been mandated as a requirement of Care Home Providers under a notice issued in 2009. These codes are used within the local NHS systems to enable the Commissioner or Health Care Provider to capture and record activity undertaken on residents within Care Homes by health professionals. Further information on ODS codes can be found www.connectingforhealth.nhs.uk/systemsandservices/data/ods

Information Standard Notices (ISNs) are notices issued to commissioners and providers by the Information Standards Board (ISB) giving instructions on information standards to be met for services offered within the NHS and adult social care in England. An information standard describes a common way of managing information, which supports national initiatives. An example of an ISN for Care Home Providers is the requirement to register the organisation and gain an ODS code which is also a requirement of the Contract under Clause 27.4 and Module B Part 6. Further information on ISNs and the ISB can be found at www.isb.nhs.uk .

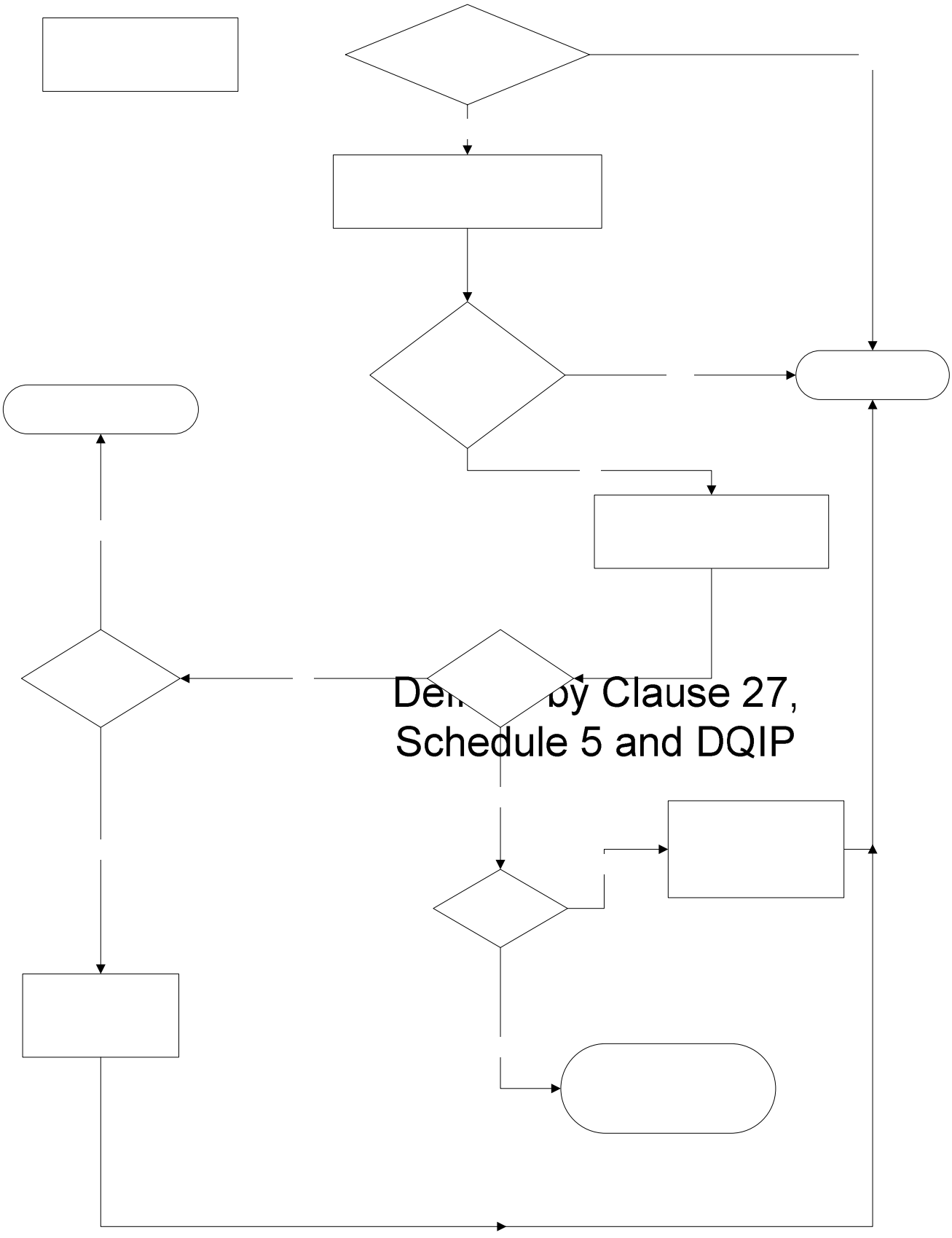
Information reporting

6.9 Care Home Providers will need to agree with their commissioners an appropriate and secure way in which to send any agreed reports i.e. NHS mail, encrypted CD.

The cost of information

6.10 Commissioners should carefully consider the relevance of the information they require to be reported, recognising there could be a potential cost on the Care Home Provider attached to the provision of information.

Figure 1



7 Quality

7.1 Quality improvement is at the heart of the standard contracts. The contracts are the means by which commissioners encourage and reward the provision of good quality services for their local populations.

7.2 Guidance relating to the Quality Requirements and CQUIN sections of Module B is set out in chapter 5 of this guidance document.

7.3 The main contractual requirements relating to quality are set out in clause 15 of Module C. These include requirements to:

- Comply with the requirements of the Regulator (i.e. CQC) and recommendations of various other bodies
- Comply with the quality requirements agreed in Module B
- Carry out service user and carer surveys
- Agree quality requirements for each contract year that are no less than those of the previous year.

7.4 In agreeing Quality Requirements each year, commissioners and providers should carefully consider the type of service being provided.

7.5 Areas for consideration may include:

- Management and improvement of health care associated infections
- Wound management
- Prevention of pressure ulcers
- Nutrition
- Dementia care
- Falls
- Advocacy
- Patient involvement
- Community involvement and integration

7.6 Under clause 30 of Module C, the provider is expected to produce a regular report, at intervals to be agreed with the commissioner, covering each month of the contract. This report should detail performance against the quality requirements, incentive schemes and occurrence of any Never Events.

8 Contract management

8.1 The contract sets out the requirement for regular review of contract performance and the process for addressing non performance by either party to the contract.

Contract review processes (Module C clause 7)

8.2 The contract requires that performance under the contract should be reviewed at least every six months. This does not need to be a face to face meeting.

8.3 In agreeing an appropriate review time schedule, the parties should take account of the size of the contract and the level of risk involved.

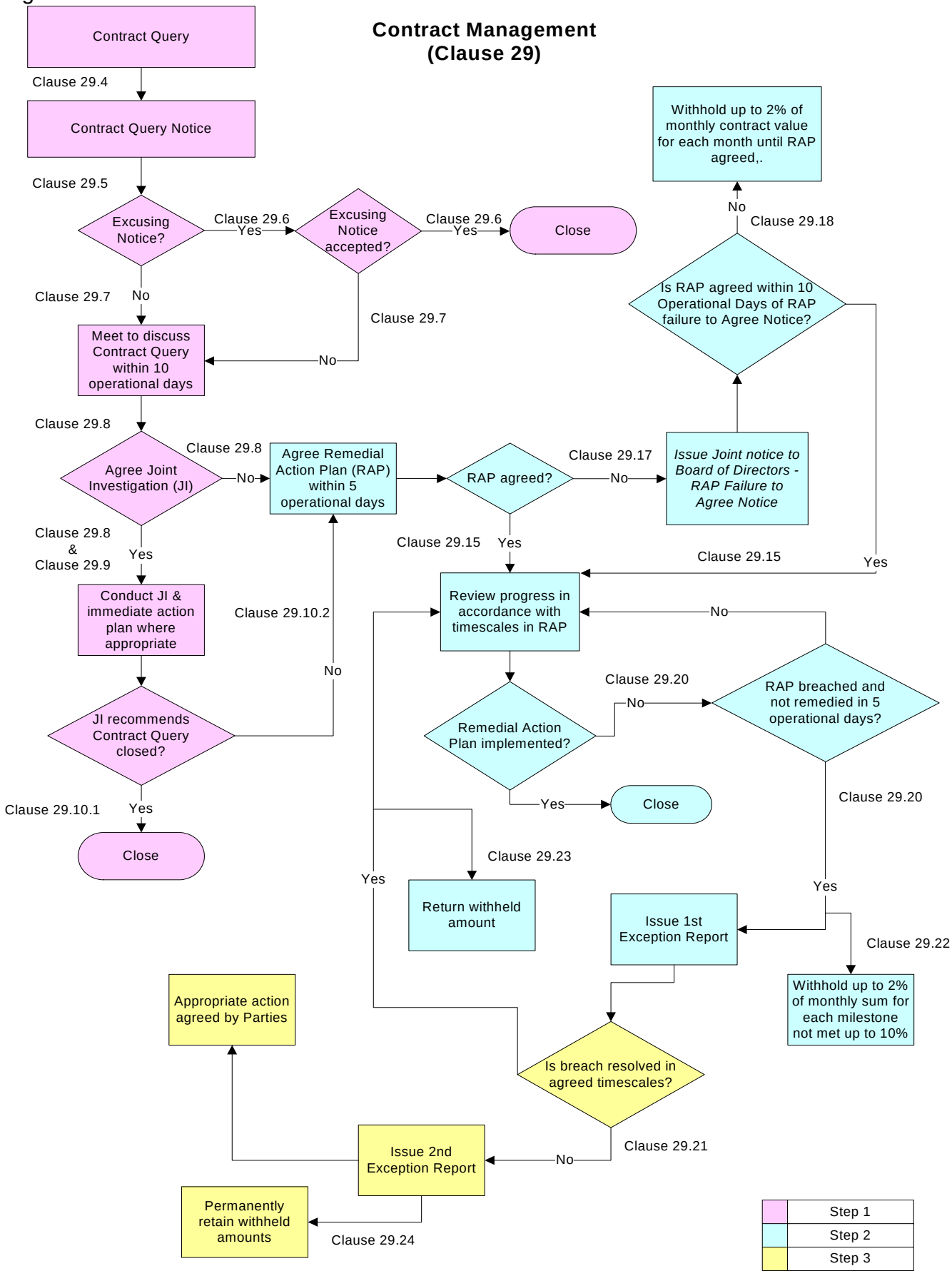
8.4 Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the Quality and Information schedules.

Contract management (Module C clause 29)

8.5 Clause 29 sets out the process for contract management where there is a problem with either party's performance under the contract.

8.6 Figure 2 sets out the process.

Figure 2


Contract Management
(Clause 29)
Contract Query
Clause 29.4
Contract Query Notice
Clause 29.5
Excusing Notice?
Clause 29.6
Yes
Excusing Notice accepted?
Clause 29.6
Yes
Close
Clause 29.7
No
Meet to discuss Contract Query within 10 operational days
Clause 29.7
No
Clause 29.8
Agree Joint Investigation (JI)
Clause 29.8
No
Agree Remedial Action Plan (RAP) within 5 operational days
RAP agreed?
Clause 29.17
No
Issue Joint notice to Board of Directors - RAP Failure to Agree Notice
Clause 29.8
&
Clause 29.9
Yes
Conduct JI & immediate action plan where appropriate
Clause 29.10.2
No
JI recommends Contract Query closed?
Clause 29.10.1
Yes
Close
Clause 29.15
Yes
Clause 29.15
Yes
Review progress in accordance with timescales in RAP
No
Clause 29.20
No
Remedial Action Plan implemented?
RAP breached and not remedied in 5 operational days?
Yes
Close
Clause 29.20
Yes
Clause 29.23
Yes
Return withheld amount
Issue 1st Exception Report
Clause 29.22
Withhold up to 2% of monthly sum for each milestone not met up to 10%
Appropriate action agreed by Parties
Is breach resolved in agreed timescales?
Clause 29.21
No
Issue 2nd Exception Report
Permanently retain withheld amounts
Clause 29.24
No
Clause 29.18
Withhold up to 2% of monthly contract value for each month until RAP agreed,.
Is RAP agreed within 10 Operational Days of RAP failure to Agree Notice?
Step 1
Step 2
Step 3

9 Frequently asked questions

9.1 The following section outlines a number of frequently asked questions in relation to the care home contracts:

What payment options does the contract allow?

These are set out in clause 6 of Module C.

Where the provider is a small provider, defined as a provider with 50 or fewer full time equivalent employees and whose contract value under the contract is £130,000 or less, they will be paid quarterly in advance.

Otherwise, payment will depend on whether there is an agreed expected annual contract value, in which case, payment will be monthly based on one twelfth of the expected contract value per month, or whether there is no annual contract value, in which case payment will be based on a monthly invoice.

What should be contained in a business continuity plan?

The requirements relating the Business Continuity Plan are set out in clause 4 of Module C. The plan should describe the provider's plans for dealing with unforeseen circumstances whose occurrence may prevent the service from operating normally. If there are services which the parties agree must continue in any circumstances, the arrangements to support this should be set out in the Business Continuity Plan. This could, for example, include service users being transferred to other services.

What contractual arrangements should we use for a one off placement?

Where a one off placement is made with a provider, the commissioner has a number of alternatives. They may seek to join as an associate with another commissioner, they may enter into a zero based contract with the provider or, where the local authority has a contract with the provider and joint commissioning arrangements are in place, they may join as an associate commissioner in the local authority contract.

Where one off placement are agreed as part of a stand alone contract, the size and value of the contract should be taken into consideration when agreeing information and quality requirements.

What are the main differences between the care homes contract and the community services and mental health & learning disability services contracts?

The care homes contract is based on the structure of the community services contract ie a modular approach. The majority of terms and conditions will be the same as the other standard contracts as the standard contracts are intended to be standard terms and conditions for doing business with the NHS. Any changes made reflect either:

- where something cannot apply to care homes or

- where it has been necessary to make a bespoke change to reflect how care home services are provided.

As the care homes contract is intended to be used only for independent and voluntary sector care home providers, all requirements which relate purely to NHS providers have been taken out. These include any requirements relating to Foundation Trust status, Freedom of Information requirements on NHS providers and counter fraud requirements for NHS bodies. The contract includes bespoke versions of clause 7 (Prices and Payment), Clause 17 (Transfer of and Discharge from Care Obligations, Clause 27 (Information Requirements) and Module D Schedule 2 (Managing Activity). Other minor wording changes have been made throughout the contract to ensure that the contract wording fully reflects care home services.