NHS
Cornwall and
Isles of Scilly

Contract Management Framework

2022/23

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Please note:
During the transition process to the establishment of the Cornwall and Isles of Scilly Integrated Care Board, this policy will remain relevant and used by NHS Kernow's clinical commissioning group. .

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1. Introduction

The Governing Body of NHS Cornwall and Isle of Scilly (CIoS) Integrated Care Board (ICB) requires assurance that the organisation has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The ICB is the commissioning authority responsible for commissioning services and ensuring contracts are in place for health services across CIoS.

To achieve this, this framework describes the way in which the ICB will develop and implement robust contract management arrangements to give the Governing Body this assurance. The arrangements will be transparent and equitable across all contracts that the ICB has put in place.

With the upcoming changes to the legal status of Clinical Commissioning Groups being transferred to Integrated Care Service (ICS) on 1 July 2022 there will be a requirement to carry out a full review of many policies and procedures across Cornwall and Isles of Scilly ICS. Therefore this 2022/23 CMF version should be seen as reflecting arrangements that evolved during the financial year and transition into the ICB.

The ICB is committed to improving the quality of services and outcomes for patients and securing value for money, through its contractual arrangements with its providers. This contract management framework (CMF) adopts good practice, working to maximise financial and operational performance, whilst minimising risk, and supporting the ICB to deliver commissioning reform.

At the end of January 2022, NHS Kernow had circa 600 clinical / health and non clinical contracts plus community healthcare (CHC) contracts / agreements and grants. These providers are within the NHS, private sector, voluntary and third sector, including community pharmacies and GP practices that provide practice-based services.

Increasingly, the ICB may take on additional commissioning and contracting responsibilities where budgets have been delegated from NHS England or integrated across different statutory commissioning organisations and where the is the lead commissioning and / or contracting organisation on behalf of others.

The commercial services team will work with Cornwall Council's commercial team to, where possible, reduce duplication and share best practice whilst recognising each organisations differing legal and governance obligations.

Some non-healthcare contracts fall outside of the scope of ICB's commercial services team, it is expected that the relevant commissioner will lead on these contracts.

The relevant contracted providers will have their own contract management monitoring arrangements which they must follow to satisfy its own governance arrangements.

2. Purpose

This CMF sets out the principles for negotiating, managing and ensuring compliance with terms and conditions of the organisations contracts. This policy provides guidance on the process for entering, documenting, reviewing and exiting contractual arrangements.

Through this policy, the ICB will establish principles that underpin management of its contracts; that result in a standardised approach to contract management with clear processes and outcomes and how they link to procurement decision making as set out in the organisation's procurement protocol

The commercial services team has co-designed the process with its staff and is continuing to work towards an integrated team approach.

This CMF focuses on the organisations approach to:

- Contract duration
- Contract storage and database (electronic and paper)
- Contract register
- Contract signing
- Contract management including:
- Activity
- Finance
- Quality
- Performance
- Assurance of standards met against DSPT, business continuity, disaster recovery, IT security
- Contract Performance Notices
- Contract Extensions
- Contract exit

Wherever possible, the organisation should consider only holding one formal contract performance monitoring (CPM) meeting with a provider (all subject areas) per month. This is obviously subject to their being no significant concern between the organisation and its provider organisations. As the majority of CPM meetings will take place virtually, and with experience indicating that these generally take less time than traditional face-to-face meetings this provides for an extended agenda, subject specialists can join as necessary for that particular agenda item.

3. Contract type and format

Contracts for Clinical Services

The NHS Standard Contract is mandated by NHS E / I for use by commissioners for all contracts for healthcare services, other than GP Contracts, must be used for all clinical services. For GP Contracts, Alternative Provider Medical Services (APMS), General Medical Services (GMS) or Personal Medical Services (PMS) should be used under direction from NHS E.

No other contracts are to be used for clinical services without approval from NHS E and the organisations chief finance officer. This includes alterations to the conditions and national requirements in the NHS Standard Contract. Except GP contracts, each healthcare contract must include the following:

- Particulars
- Service Conditions
- General Conditions

The commercial services team will advise commissioners on the appropriate contract type to use, which will be based on either:

Full Form Contract

The full version of the contract must be used for services that cover Acute, Cancer, A&E, Minor Injuries, NHS 111 or Emergency Ambulance services, or any other hospital inpatient services, including mental health and learning disabilities.

In addition, it is expected that this version will be used for services with a high contract value being delivered by large provider organisations.

Short Form Contract

The shorter-form contract can only be used for non-inpatient mental health and learning disability services, for any community services, including those provided by general practices, pharmacies, optometrists and voluntary sector bodies, for hospice care / end of life care services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.

Restricting use of the shorter-form contract, in this way, significantly reduces the number of requirements which it has to be included.

NHS Standard Contracts

The latest NHS Standard Contracts, and associated documents, can be found on the NHS England website. The contract for the latest year along with previous year's contract templates are available to view. The technical guidance document is a useful document to support the population of the contract https://www.england.nhs.uk/nhs-standard-contract/

NHS E / I undertake an annual review of the NHS Standard Contract and associated guidance, the current and previous years versions can be found contract https://www.england.nhs.uk/nhs-standard-contract/

Contracts for Non-Clinical Services

The commercial services team will provide the relevant procurement advice and ensure that regulations are adhered to. Crown Commercial Services on behalf of the public sector have published a template for use for contracts for non-clinical services, although not mandated by NHS E, this should be the preferred option if there is no existing contract template available.

Contract Referencing

When creating the contract, under the heading of contract details, the contract reference number will be issued by the commercial services team. Under the heading of Coordinating Commissioner, the organisation's name should be typed as: NHS Kernow Clinical Commissioning Group or any subsequent organisational name.

4. Commissioning and contracting cycle

Contract life cycle management "is the process of systematically and efficiently managing contract creation, execution and analysis for maximising operational and financial performance and minimising risk[1]".



Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

[1] The Chartered Institute of Purchasing and Supply

Pre-Contract Award:

- Identify Commissioning Need
- Develop Specification
- Business Case
- Procurement Process

The NHS continues to face increasing pressure to reduce costs and improve financial and operational performance. New regulatory requirements, globalisation, increases in contract volumes and complexity have resulted in an increasing recognition of the importance and benefits of effective procurement and contract management.

The growing recognition of the need to automate and improve contractual processes and satisfy increasing compliance and analytical needs has also led to an increase in the adoption of more formal and structured contract management procedures.

It is worthwhile noting that contract management is successful if:

- The arrangements for service delivery continue to be satisfactory to both parties,
- The expected business benefits and value for money are being achieved
- The supplier is co-operative and responsive
- The organisation understands its obligations under the contract
- There are no disputes
- There are no surprises
- Professional and objective debate over changes and issues arising can be held
- Efficiencies are being realised



Expanded ‘Monitoring and evaluation’ following the Procuring Services.

5. Governing principles

Proportionality: All the organisation’s contracts will be managed in proportion to their value, clinical risk and available resources.

Propriety: All contracts will be managed in line with recognised good practice and the organisation’s contract management policy.

6. Roles and responsibilities

The contract manager / lead will be responsible for ensuring full compliance with this CMF, in conjunction with other identified leads. Each entry on the contracts register (CTM) will be assigned a:

- Director or Assistant Director / Budget Holder
- Contract Lead
- Commissioning Lead
- Finance Lead
- Business Intelligence Lead
- Quality Lead
- Administrator

The above will form a **‘matrix team’** around each contract.

Below is an outline of the roles and responsibilities expected of the identified individuals:

Designation	**Roles and responsibilities**
Director or Assistant Director / Budget Holder	• Agree final budget / contract value • Sign off invoices within time scale • Overview of under / over performance • Initiating any contract investigation • Accountable Officer for identified contracts
Contract manager / lead	• Be responsible for assisting in the negotiating, managing and reviewing contracts • Coordination of contract negotiation working closely with commissioners and finance leads • Coordination of contract sign-off / variations • Contract management for a number of contracts • Hold regular contract review meetings with providers to seek assurance on compliance • Ensure robust reporting requirements are included within all managed contracts and • escalate areas of concern to Commissioning Lead • Co-ordinate with commissioners the prioritisation of contracts due to expire • Co-ordinate contract proposals from commissioners and align to procurement protocol • Review and keep current the Contract Register “CTM” • Undertake an annual audit of contracts against this CMF, presenting findings to the finance and performance committee
Commissioning lead	• Lead for negotiation and developing system outcomes on behalf of the CCG • Responsible for updating the service • specifications ensuring the correct outcomes and KPIs are assigned to contracts

	• Responsible for performance / service delivery • Preparation and submission of Business Cases to the finance and performance committee in relation to any contract extensions / contract variation or de-commissioning of services • Has strategic overview of similar services • Support the development of Quality, Innovation, Productivity and Prevention (QIPP) schemes • Provide professional expertise into key performance issues and service development planning.
Finance lead	• Gathers, analyses and reconciles financial data • Produce variance analysis reports and highlight exceptions to Budget Holder / Contract Lead • Receives, co-ordinates and validates invoices • Produces financial reports and tables; • Prepares in-year and year end reconciliations • Challenges providers financial data within defined contract timescales • Calculates, monitors and reports on contract variations, sanctions and penalties • Shares information with the Contract Lead for contract management and capture in the contract management system • Prepares annual contract value statements and local finance schedules.
Business Information (BI) Lead	• Receives data from providers • Manages safe data collection • Analyses and produces reports to support • contract management, commissioning leads and budget holders • Undertakes ‘deep dive’ investigations

	• Compares and challenges performance changes • Shares information with the Contract Lead for contract management.
Contract Administrator	• Responsible for managing input, updating and removal of information from the Contracts Register • Provision of administrative support to prepare standard contract documentation and support in the issuing and signing of required documentation • Management of providers against the terms of their contract • Provision of administrative support to the contract and procurement team and for defined key contracts • Prepare an annual workplan of CPM meetings for submission to Quality & Performance (Q&P) Committee for noting • Ensure providers submit data returns as specified within the contract in a timely manner • Support the Contract Lead in relation to any 'Deep Dive' investigation • Be the second point of contact for any contractual issues / matters.

It will be the responsibility of all parties to triangulate clinical and non-clinical intelligence to understand implications on patient care, patient safety and quality performance ensuring actions are agreed and implemented to achieve optimum performance with the highest standards of patient safety, experience and clinical effectiveness. It is expected that Contract Managers will meet with the relevant Commissioning Lead on a regular basis to go through all contracts, issues and next steps. They are to work collaboratively, ensuring that individual roles and responsibilities are adhered to.

7. Contract duration

Unless otherwise agreed by the organisation's executive management team (EMT), and subject to funding availability, the following should be adhered to:

Duration

Contracts should be let:

- For contracts not procured, the default contract length will be based on the recommended duration set by the organisation's finance and performance committee for clinical contracts, generally 2 years
- Any contracts for pilots, non-recurrent investments or short-term projects are to be for a maximum of 1 year
- The same applies to any contracts awarded without a procurement (subject to
- tender waivers)
- Any contracts following a competitive procurement are to be based on the level of recurrent funding approved and can be up to a maximum of 5 years
- Contracts longer than 5 years require approval by the Governing Body prior to advertisement. Prior to procurement, commissioners are to consider carefully what benefits they can expect from offering providers the increased certainty of a longer-term contract, setting this against the need to ensure that they can use a competitive procurement approach when this will be in patients' best interests, in line with regulations and guidance.

Commissioners should consider patient choice, competition, the likelihood of technological and other developments affecting service delivery models, all relevant commercial and market considerations, in determining the appropriate length of contract before going out to procurement.

In addition, contract length should be considered in conjunction with any right to extend the contract and / or the consequences of early termination.

Extensions

The following guidelines are below:

- Extensions are not a mandatory requirement; however, the default extension period will be 1 year for all standard contracts or to the end of the financial year 31 March if a different timeline is required.
- Extensions should only be included in contracts where competitively tendered and as advised in tender documents
- However, for a pilot or short-term projects these are to be for a maximum of 12 months, any extension beyond that will require agreement from Finance Committee with commercial input and a procurement plan.
- There will be no extension periods for non-recurrent investments
- The maximum extension term shall not be longer than the original duration of the contract
- Extensions can only be used once.

It is expected that commissioners make clear the length of the contract and possible

extensions (if any) at the very outset of any procurement process or within any single action tender waiver during which time a procurement process will be planned.

Good contracting practices indicate that any contract performance notices (CPN) should be resolved before any offer of an extension is offered.

These guidelines are not mandatory and are to be exercised at the discretion of commissioners and the organisation, or as directed by NHS E.

Contract Variations

It is expected that Commissioners will ensure that the ever-changing health needs of the population are reflected in the current contracts that they commission. The commercial services team will support this with the use of contract variations with the likelihood that contracts will need to be changed several times throughout its lifecycle.

Commissioners and contract managers should refer to NHS Standard Contract General Condition (GC13) for guidance on contract variations (except GP Contracts which has its own process of variation). Each year, National Contract Variations must be issued, as mandated by NHS E, to all Providers with existing NHS Standard Contracts to ensure the terms and conditions are brought in line with the requirements of the current year's NHS Standard Contract. Local Variations may also be proposed by either the Commissioner or Provider. Any Contract Variation relating to Service Specifications should have the same duration as that to which the contract itself applies to.

The same process applies to any contracts that need extending.

Further detailed guidance on the variation processes is available at: https://www.england.nhs.uk/publication/guidance-on-the-variations-process-full-length-and-shorter-form-contracts-2/

8. Annual uplifts

Annual contract uplifts are applied as per the process held in appendix 1, which was ratified by the finance and performance committee and who oversee the application of the process.

It should be noted that not all contract agreements are entitled to annual uplifts.

9. Contract storage

All forms of contract documentation, paper or electronic, must be stored in accordance with GDPR regulations and NHSX records management code of practice 2021 which will be available for audit at any time.

Electronic master copies of all organisational contracts held by the commercial services team are stored on the network under the following shared drive S:\SED\KernowClinicalCommissioningGroup\KCCG\Category Management. Access is via authorised control. The CTM contract management data base is also under development to hold copies of contracts and has an authorised access control.

Paper master copies will be stored in locked designated cabinets at the Penwinnick Road office in St Austell with authorised access controls in place.

Commissioners and other delegated contract management support may hold copies of contracts, however it will be the responsibility of these individuals to ensure that each copy of these is saved electronically for reference and audit purposes.

Contract reports, delivered by providers as part of the contractual requirements, will be stored on IRIS (Contracts >> Reports & Documents) and will be regularly reviewed as determined by the Contract 'Matrix team'.

10. Contract register

The commercial services team will ensure that the contracts register is reviewed and maintained. The contract register is a full e-procurement and e-contract management system that can enable all aspects of procurement and contract management to be managed inside one portal. The portal has a full audit history and a task management system. Commissioners and Providers can be added to the system in time.

A quarterly update of clinical and non-clinical contracts will be provided to EMT. The procurement pipeline of up-and-coming procurements is a monthly standing report to the finance and performance committee.

Currently it is a mandated requirement that the full contract register is published on the organisations public website which is refreshed annually in April. The register will be amended to include CPV codes to assist providers identifying services. In addition, any procurements awarded and up and coming procurements are published on the public website, this is updated quarterly.

All contracts awarded through procurement must be published on Find a Tender by the end of the quarter they were let, this is a mandatory requirement.

11. Contract management

Contract review meetings are a mandatory requirement for all NHS contracts. Commissioners will be required to hold contract review meetings with the providers they commission services from, with the number and frequency determined by financial and clinical risk.

These will be supported and, in some cases, led by the commercial services team who will be responsible for formal minutes or action logs which are to be maintained for all contract review meetings held with the providers. In addition, if meetings are not held in accordance with the timescale stated within the contract, this should be formally documented.

All contracts must be supported by documentation covering the contract period and be signed and dated by both parties.

All key high value and / or high-risk contracts (see table below) will be fully contract managed by the commercial services team (who will be the contract owner) as well as all contracts where the ICB are a co-commissioner and are of high value / risk.

With regards to APMS, GMS and PMS Contracts the ICB must adhere to the requirements contained within the delegation agreement in performing their obligations in giving NHS E assurance on compliance.

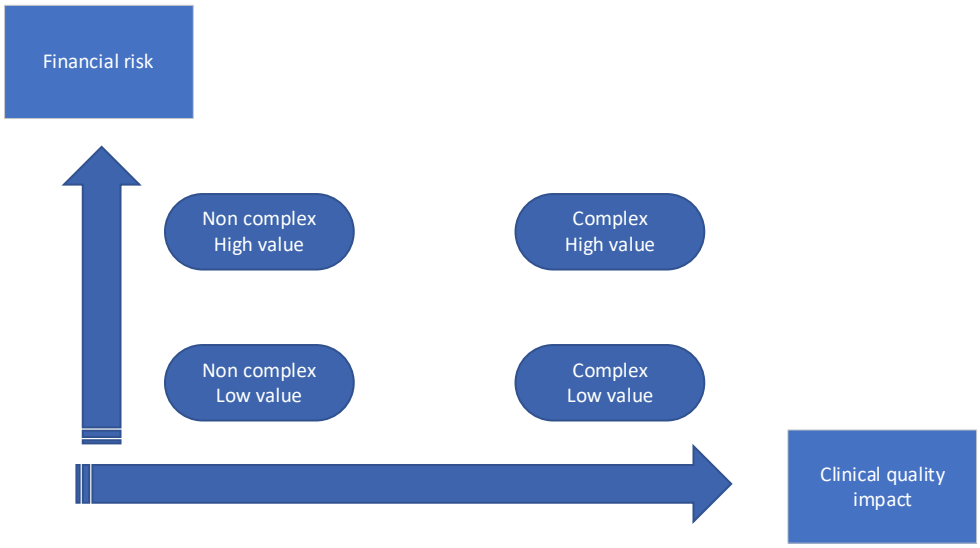
Resource tiers

Resource ranging / tier	Description
1	**High Resource Contract** Key, high value (**greater than £20M**), high activity contracts i.e. main acute, community and mental health Providers). Requires constant monitoring and proactive management. Will require senior roles to manage this contract across the functions. **Monthly CRM Meetings**
2	**Upper-Mid Resource Contract** Key, high value (**circa £2M to £20m**), high activity contracts i.e. main acute, community and mental health Providers) or acting as Lead Commissioner of mid-sized providers, including AQP contracts, that require monthly monitoring, financial reconciliation and contract review meetings. Less senior input required for these providers. **Quarterly CRM Meetings**
3	**Lower-Mid Resource Contract** For smaller value contracts (**circa £200k to £2M**), that require less frequent (quarterly) meetings monitoring, financial reconciliation and contract review meetings. Able to be managed by less senior members of the service. Larger emphasis on the transactional / payment relationship. **Annual CRM Meetings**
	Low Resource Contract (Transactional) For smaller value contracts (**below £200k**), that require less infrequent monitoring, financial reconciliation and contract review meetings. Also if an Associate Commissioner for a higher tiered contract. Predominantly a financial / transactional relationship, with

4	monthly coding and checking of invoices. **Annual CRM meetings** or should there be matters of material note that emerge in year, more frequently (traditionally much lower, activity, value contracts).

Further assessment is undertaken dependent on the complexity of the service delivered as part of the following decision matrix.

Decision matrix



As a guide a definition value and complexity could be as follows:

- Complex Inter dependencies on other services or providers
- Value +£1m = High
  -£1m = Low

The evaluation of each contract will also need to take into account performance, quality, financial control and engagement.

The monitoring arrangements for GP Estate contracts / leases are managed within The primary care team.

The following table gives an indication of which tier our contracts, or group of contracts, belong to:

Organisation	**Contract tier**
Royal Cornwall NHS Hospital Trust (RCHT)	1
Cornwall Partnership NHS Foundation Trust (CFT)	1
Cornwall Council	1

University Hospital's Plymouth (UHP)	1
Other NHS Providers	2
Independent sector	2
Community provision (for example: pharmacies/optometrists)	3
GP contracts (APMS / GMS / PMS) includes locally commissioned services	3
Community health care (CHC)	4
Voluntary sector	4

The contract review process is set out in the NHS Standard Contract General Conditions (GC8 Review): https://www.england.nhs.uk/nhs-standard-contract/

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

Clinical leads and commissioning managers will determine representation at contract monitoring meetings. All this should be clearly covered within respective terms of reference (ToR), which should be reviewed at least annually.

ToR for each contract will include, as a minimum:

- Purpose
- Membership
- Conflicts of Interest / Declarations of Interest
- Principles
- Frequency, including arrangements for extra ordinary / emergency meetings
- Quorum
- Roles & Responsibilities
- Use of General Condition 9 (Contract Management) (GC9) and local escalation
- Reporting
- Governance Arrangements
- Authority
- Review
- Formal minutes

Formal minutes and / or action logs need to be maintained for all contract performance monitoring (CRM) meetings held with providers. In addition, if the meetings are not held in accordance with the timescale stated within the contract / ToR, then this should be formally documented including a clear rationale.

CRMs will focus on the following as necessary or as determined within the ToR:

- Relationship Management
- Performance
- Commissioned Services, includes levels of activity, referrals and utilisation

- Finance
- Quality
- Review of KPIs and standards
- Triangulation of data and forward planning

The actual meeting structures for each contract will be designed to ensure the following functions are met, with the ability to flex the requirements being proportionate to the scale, complexity and level of risk in the contract.

The main section of agendas should include the following as a minimum:

- Welcome and Introductions
- Conflicts / Declarations of Interest
- Minutes from the Previous Meeting, including review of Actions
- Contract Management
- Performance Monitoring
- Finance Monitoring
- Quality, including clinical risks
- Service Developments
- Governance
- Risk Register
- Any Other Business
- Next meeting dates / time
- Forward workplan

Following each review meeting, the commissioner and the provider must review and agree a record of the meeting (without limitation), all the matters raised during the review, actions taken, agreements reached, disputes referred to dispute resolution, and any variations agreed. Minutes and actions must clearly document a responsible officer and clarity around expected outcomes.

If any dispute which has arisen during the review is not shown in the review record or is not referred to dispute resolution within 10 operational days after signature of that review record, it will be deemed withdrawn.

Any disputes should follow the NHS Standard Contract GC9 guidance which provides details on the process around contract performance notice (CPN) and dispute resolution.

A CPN can be issued if the provider is failing to meet either the quality, performance or expected standards of the contact.

An information breach notice (IBN) can be issued if the provider is failing to provide the required information or data to support activity and KPIs.

Activity query notices (AQN) can be raised by either providers or commissioners to gain clarity around preserved inconstancies in activity.

The commercial services team will support this process and ensure that the correct process is followed as per GC9.

Process

- Initial disputes should be discussed in an open, professional and transparent manner with the provider either in CPM meetings or separately as required
- Commissioners should establish an action plan with the provider before considering a formal notice, that is specific, measurable, attainable, relevant and timely (SMART).
- A formal CPN should only be issued as a last resort
- The same applies to the closure of a formal notice
- Once a notice has been issued an escalation meeting will be arranged by the commercial services team within the required 10 operational days
- The escalation meeting must be attended by the Lead commissioner, provider head of contracting and a director (or nominated deputy(s))
- Further discussions will take place at routine CRM meetings or further escalation meetings if required.

12. Contract Review Meetings – Governance

The ratified minutes and or actions from CRM meetings will be shared with organisations finance and performance committee, in summary forma for all contracts held in tier 1 and 2. If CRM meetings have not taken place this will also be included within the monthly report.

Each CRM will have its own risk register / action log which will also be available
To the finance and performance committee for review and escalation as necessary, reporting back to the relevant CRM meeting.

In additional ratified minutes / actions from other meetings relating to contractual performance will be included within the monthly update to the committee.

The Chair of the committee will provide an update to Governing Body as part of the overall chair report.

Were possible regular CRM meetings should take place virtually, if circumstances allow, at least 4 meetings (quarterly) should be ‘face-to-face’ per year.

Digital Recording of Meetings

The digital recording of meetings as an aide memoir to the minute-taker is often required. If the meeting is to be recorded for this purpose, the following guidance

should be followed:

- The contract administrator will be responsible for creating the meeting with relevant privacy settings, invitation list and ensuring no additional guests or channel meetings/chats are created.
- There would need to be agreement by all members to audio record the meeting, explaining that this recording would be used purely as an aide-memoire for the minute-taker to ensure an accurate transcript of the meeting.
- Written consent should be obtained from all members agreeing for the meeting to be recorded.
- Updated ToR will identify the need for agreement to record the meeting, the reason for recording the meeting, where / who will have the only copy of the audio recording and when the recording will be destroyed.
- The Chair of the meeting has discretion to stop or suspend recording if, in their opinion, continuing to do so would prejudice proceedings at the meeting.
- Prior to meetings, communications should be sent notifying members that the meeting will be digitally recorded. This should also be identified on the formal agenda.
- All panel members should be advised that the digital recording will be held for:
    - The same retention as the written transcription for high / board level meetings, i.e. 3 months.
    - A minimum of 3 months after the written transcript has been ratified by all members for lower level meetings.
    - The recording should then be destroyed once the above stated retention period has been met.
    - As the audio recording would be a record for the above agreed time, it is important to record the destruction of this record to assist in audit purposes.
- As the audio recording would be a record for the above agreed time, it is important to record the destruction of this record to assist in audit purposes. The contract administrator will be responsible for deleting the recording from all storage areas within 4 weeks of the recording date.

13. Contact performance notices

GC9 outlines the process to be followed in the issuing, and eventual resolution, of issued CPN, likewise Section 45 of the 2021/22 NHS Standard Contracts - Technical Guidance (Contract Management) states that CPN can be issued by either party.

Therefore prior to issuing a CPN this should be discussed and clearly documented at the appropriate CPM meeting and included within that provider's risk register.

All correspondence in respect of issued CPNs must go via the appropriate provider CRM meetings.

In exceptional circumstances EMT can authorise the issuing of CPN's, in the absence of a suitably timed CRM meeting, thereafter the appropriate CRM meeting will take over

the monitoring and onward reporting of the issued CPN. If for any reason CRM meetings have been paused the approval to issue, monitor and eventual withdrawal of CPN's will be the responsibility of EMT.

Any Cornwall and Isle of Scilly (CIoS) group, meeting or committee can recommend to the relevant Chair of a CRM meeting to consider the need for a CPN to be issued.

The operational board meeting will have oversight for the monitoring of the agreed remedial action plans (RAP) and act as an independent check on progress, reporting into the finance and performance committee's monthly contract report.

14. Contract compliance audit programme

Commissioners are required to incorporate contract compliance audits into the annual contracting monitoring process, in line with NHS Standard Contract (GC15 Governance, Transaction Records and Audit).

The Provider must comply with all reasonable written requests made by any relevant Regulatory or Supervisory Body (or its authorised representatives), the National Audit Office or its appointed auditors, or any Authorised Person for entry to the Provider's premises and / or the Services Environment and / or the premises of any Sub-Contractor for the purposes of auditing, viewing, observing or inspecting those premises and / or the provision of the Services, and for information relating to the provision of the services.

The contract manager will work with, as a minimum with the quality and commissioning lead as well as the provider lead to support the development of the annual contract compliance audit programmes.

15. Performance management against contracts

Performance management should be used to provide assurance in the system of the effectiveness, efficiency and quality and safety of services.

It assists in identifying areas of best practice, focuses on continuous improvement and delivering improved outcomes, ensures delivery of high quality and safe services to patients and the organisational strategy is delivered.

Performance indicators are used across health and care systems to monitor and compare performance. The indicators may be set as national indicators such as those contained within the NHS Standard Contract and the NHS system oversight framework or they may be locally defined within service specifications / contracts.

In order to effectively assess and manage performance, it is important that multiple data and information sources form part of the performance management and accountability framework to ensure an integrated and comprehensive view. Key performance

indicators (KPIs) will be drawn from a variety of sources and will cover a wide range of themes to provide sufficient assurance on the quality and efficiency of service delivery.

The NHS Standard Contract contains a number of mandated schedules and metrics which providers are required to comply with and report against. The local quality requirements will be reviewed and set each year this is to ensure that the KPI's reflect local, contractual and regulatory needs and are appropriate to the size / key activities of the organisation.

In appendix 2 the following can be found:

- Table 1 sets out the contractual reporting requirements.
- Figure 2 demonstrates the performance escalation process
- Table 3 describes the escalation process for activity, finance and contractual performance
- Figure 4 demonstrates the quality assurance process

16. Contract exit and expiry / termination

The process to terminate, or end a contract, should be in line with the NHS Standard Contract General Conditions (GC17 Review).

The commercial services team will hold the relevant notice periods for all contracts and will flag with the relevant commissioner prior to this date. It is expected that commissioners do a service review at least 9 months before the end of the existing contract to enable a procurement or collaboration process to commence. Where a commissioner is evaluating options upon termination or expiry of an existing contract, the decision-making process and key factors to be considered will be broadly like scenarios where the commissioner is seeking to secure new service models or significant additional capacity. The main difference is that the commissioner is considering options and making decisions in relation to existing services. This may involve (but not exclusively):

- a transitional or exit plan for the new provider or existing providers (if applicable).
- whether to contract is to be extended.
- obtaining the appropriate sign off as per the ICB's governance process, in time before the relevant notice period.

The service review process will follow the de-commissioning and dis-investment policy and should conclude with recommendations at least 9 months before the end of the existing contract. Where a commissioner is evaluating options upon termination or expiry of an existing contract, the decision-making process and key factors to be considered will be broadly similar to scenarios where the commissioner is seeking to

secure new service models or significant additional capacity. The main difference is that the commissioner is considering options and making decisions in relation to existing services.

The commercial services team will support with any termination or expiration letters along with publication of the variation or termination notice through contract finder and find a tender service. The commercial services team will also support any contractual disputes relating to existing issues and / or with the exit plan.

17. Contract signing

The contract creates legally binding agreements between the Commissioners and the contracted providers. Agreement between commissioners and NHS Trusts are NHS contracts as set out in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract and it should be treated with the same degree of rigour and seriousness as if the agreements are legally binding.

Contract signing will need to be in line with the ICB's scheme of delegation (SoD). All contracts must be signed, in most cases, by the chief finance officer and provider in advance of the service commencement date. Each party must ensure that the contract is signed by an officer with the appropriate delegated authority.

A contract brief is prepared by the commercial team to accompany the contractual document for signing. The brief sets out a summary of the key contractual information and is endorsed by the Commissioner Lead, Contract Manager, Finance Manager and the Head of Contracts & Procurement to ensure all governance and relevant departments hold and agree the contract holds the correct information.

If a group of commissioners wish to enter into a contract with a provider, the NHS guidance around Lead Commissioner arrangements must be observed. Where possible contracts should be physically signed, electronic signatures are acceptable where this is the most pragmatic way to proceed.

Contracts will be presented for signing to the relevant officer as set out by the organisations scheme of delegation (SoD). The contract will be accompanied with a full contract brief, prepared and validated by the contract matrix team, and where appropriate a single action tender wavier form (SATW).

The coordinating commissioner should maintain a record of all contract signatures and provide copies to other commissioners for audit Purposes. A Commissioning Collaborative Agreement will be created setting out the obligations and responsibilities of the Lead and Associate Parties.

18. Statutory publications

Statutory Guidance issued by NHS E requires CCGs to ensure that there is transparency regarding contracts awarded, including how conflicts of interest have been managed and the details of those involved in the decision making (key individuals and decision-making forums).

When managing contracts, specific regard should be given to the following (as may be amended):

- Public Contracts Regulations 2015
- NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
- Monitor's substantive guidance on the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
- Health & Social Care Act 2012
- Public Services (Social Value Act) 2012
- Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (NHS England, June 2016)
- Transfer of Undertakings and Protection of Employment Regulations (TUPE) 2006
- Equality Act 2010
- Bribery Act 2010

Regard will also be given to applicable guidance as may be published from time to time by: The Cabinet Office; Department of Health; NHS E / I.

19. Related organisational policies

Performance management and accountability framework
Procurement framework

Appendix 1: Annual uplift process

The Uplift Panel is managed by the finance directorate for financial control with all recommended decisions signed off by the appropriate Budget Manager and SRO.

The Panel will:

Collate all known information across the various Directorates and circulate ahead of the Panel date.

Meet monthly with Uplift requests in date received order.

Agree the % uplift, when the uplift will apply from and escalate any that cannot be agreed within the 3% cap.

Ensure the uplift is administered in Broadcare, the Contract and Finance/Invoicing systems.

Reject requests where they the risks are low, specifically around the strategic importance of the Provider, number of packages or risk of handback of packages, or Providers who will not enter into an NHS Contract.

Counter offer an agreed uplift, up to 3% if any of the criteria above are important

All decisions would be documented

A monthly paper would go to the SRO and Budget Managers setting out progress to date plus seeking decision on any requests above 3% that rejected our 3% counter offer.

Out of Scope would be Joint Packages of Care commissioned with Local Authority. Currently the Finance Directorate has little or no involvement with this process but are impacted by requests from Providers who are seeking the CCGs agreement to uplifts values agreed with the Local Authority.

NB: April/May 2022 – this process is currently under review as it has not been in use during the covid pandemic.

Appendix 2

Table 1: Mandated contract reporting requirements

		Relevant schedule	Responsible team
Contract Management, reporting and information requirements	NHS standard contract schedules - particulars	• Schedule 2B activity plan • Schedule 2C Activity planning assumptions • Schedule 6A reporting requirements • Schedule 6B Data quality improvement plans (DQIP) • Schedule 6C Incident reporting • Schedule 6D Service Development and • Improvement Plan (SDIP) • Schedule 6E surveys (Friends and Family Test, staff)	

Quality	NHS Standard contract Schedule 4 Quality Requirements
	
	A. Operational Standards
		• RTT wait times:
		  • Diagnostic wait times
		  • AED waits
		  • Cancer waits - 2 week
		  • Cancer waits- 31 days
		  • Cancer waits- 62 days
		• Ambulance waits
		• Mixed sex accommodation breaches
		• Cancelled operations
		• Mental Health CPA
		• Zero tolerance MRSA
		• Clostridium difficile rates
		• RTT waits over 52 & 104 weeks
			Commissioning team
			
			Commissioning team
			Commissioning team
			Commissioning team
			Commissioning team
			Infection control team
			Infection control team
			Commissioning team

	B. National Quality	• Ambulance handover (4 KPIs)	Commissioning team

	Requirements	• AED 12 hour waits • Second time cancelled operations • VTE risk assessment • Duty of candour • Early intervention in psychosis • IAPT (2 KPIs) • E prescribing for chemotherapy • Sepsis screening	Commissioning team Commissioning team Infection control team Quality team Commissioning team Commissioning team Medicine optimisation team Quality team
	C. Local quality requirements D. CQUIN indicators E. Local Incentive scheme F. Clostridium Difficile		Quality team Quality team Quality team Infection control team

Figure 2: Performance escalation

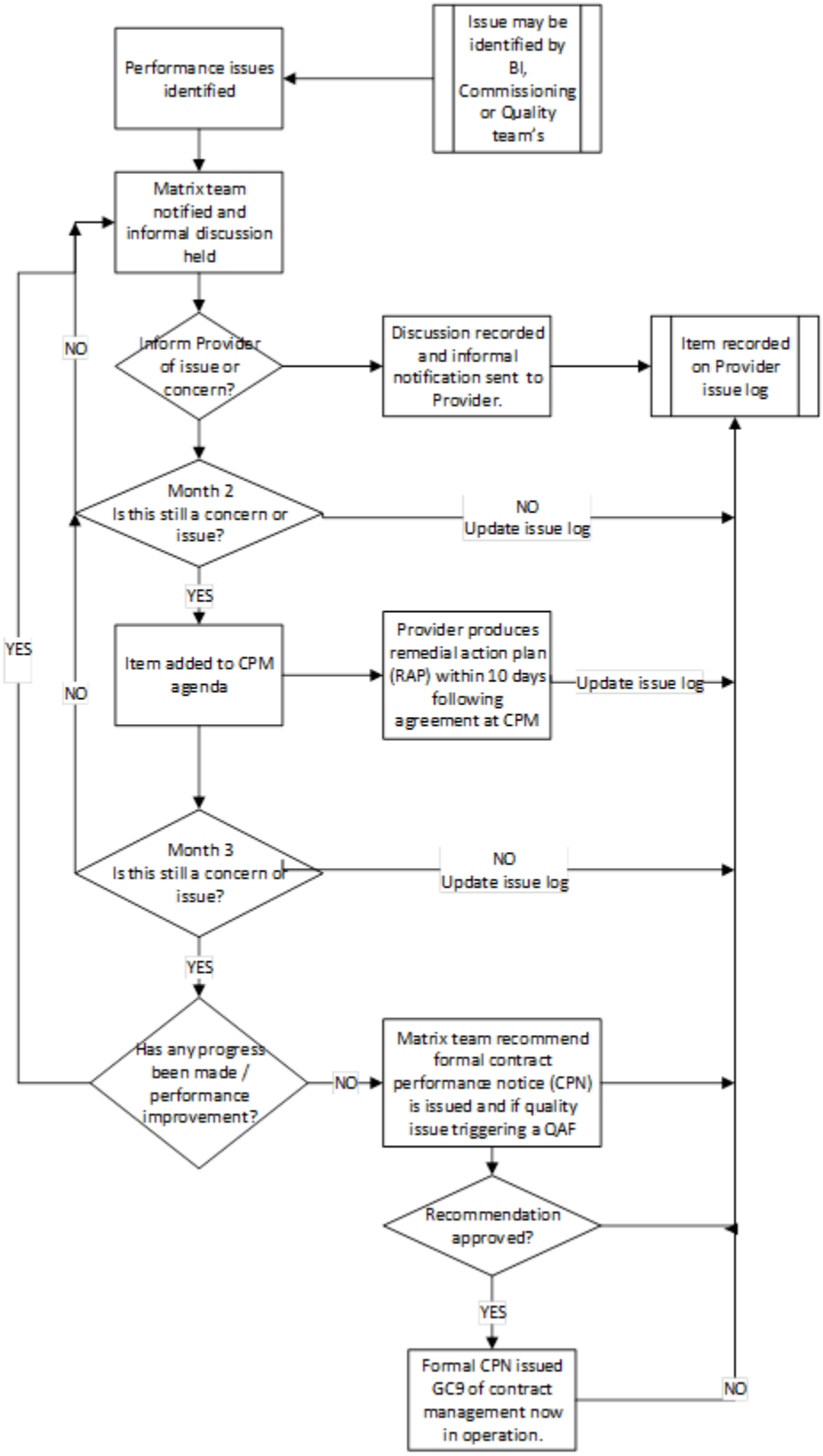


Table 3: Process description for Escalation Process Activity, Finance and Contract Performance

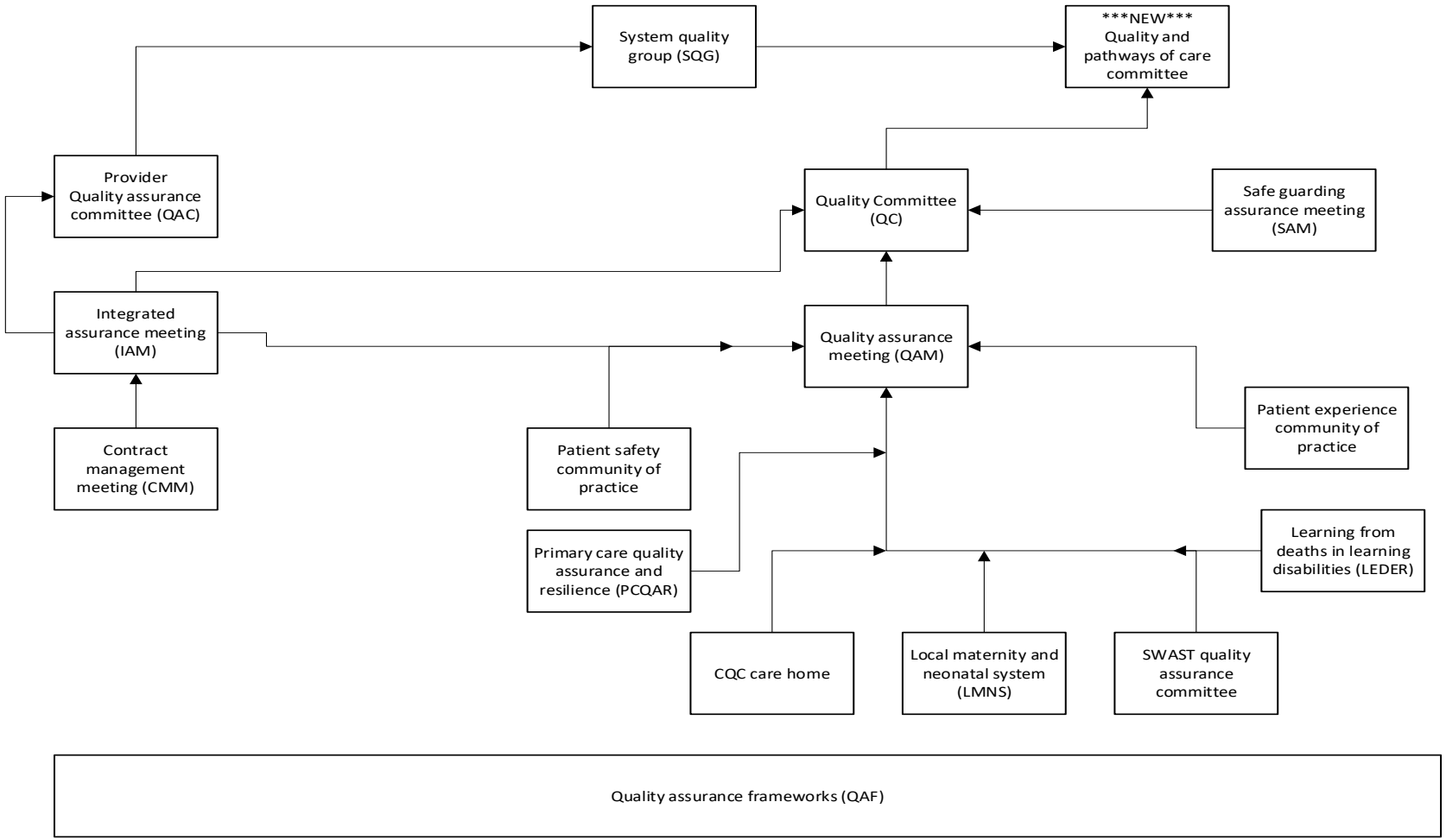
Purpose: The purpose of this process is to ensure that performance management is effective, that decisions are made in the appropriate place and that there is effective, that decisions are made in the appropriate place and that there is

Scope: The scope for this process is performance issues related to activity, finance and contract performance**.**

Step	Process	Notification/approval/audit trail
1	Performance issue identified This process is triggered when performance is off target for one month is on target but has deteriorated for 3 consecutive months	The performance issue will be raised with the relevant commissioning manager, quality and commercial services teams.
2	Informal Conversation A conversation will take place with the relevant provider	Notes of the conversation will be made and send to the provider. The issue will be added to the issue log. The integrated finance quality and performance committee will be informed via the monthly reports.
3	Month 2 – still off target Performance is still off target or is on-target but still deteriorating	
4	Discussed at Formal meeting The performance issue will be discussed at CPM meetings. The provider trust will be asked to describe what mitigating actions they will be taking to bring performance back on target	Issues log will be updated. Issues log reviewed at integrated finance quality and performance committee. The relevant commissioning manager, quality and commercial services teams will be updated.
5	Decision point – Assured Sufficient assurance will be deemed to have been provided if the following are in place:	Issues log will be updated. Issues log reviewed at integrated finance quality and performance committee.

	1. A trajectory for improvement 2. A robust action plan 3. Quality and Safety concerns addressed In this case the performance issue will continue to be discussed at CPM until performance is back on track. If any of the above is not in place assurance will be deemed to not be sufficient and the process will proceed to the issuing of a CPN.	The relevant commissioning manager, quality and commercial services teams and the integrated finance quality and performance committee. Do we need to inform NHSE/I??.
6	Recommend formal CPN The recommendation will go to the finance and performance committee for approval. If approved the process will proceed to the issuing of a CPN. If not approved the performance issue will continue to be discussed at CPM	Issues log will be updated Issues log reviewed at integrated finance quality and performance committee The relevant commissioning manager, quality and commercial services teams and the integrated finance quality and performance committee
7	Formal CPN A formal CPN is issued following the NHS Standard Contract process.	Issues log will be updated Issues log reviewed at integrated finance quality and performance committee The relevant commissioning manager, quality and commercial services teams and the integrated finance quality and performance committee. Do we need to inform NHSE/I??.

Figure 4: Quality assurance process



Appendix 3: Impact assessment

Download the latest impact assessment.

Appendix 4: Pre-ratification checklist

This can be used by authors, reviewers and by ratifying bodies and can be attached to a policy or similar document when submitted to the appropriate committee, group or individual for consideration and ratification.

Title of document being reviewed	Yes or no	Comments
Is the title clear and unambiguous?	Choose an item.	
Is the reason for the document stated?	Choose an item.	
Has a reasonable attempt been made to ensure relevant expertise has been included?	Choose an item.	
Is there evidence of consultation with stakeholders and users?	Choose an item.	
If appropriate, has there been clinical input?	Choose an item.	
If appropriate, has the joint partnership committee been consulted?	Choose an item.	
If appropriate, has the counter fraud specialist been consulted?	Choose an item.	
Are the objectives and intended outcomes clear?	Choose an item.	
Is the target audience clear and unambiguous?	Choose an item.	
Are key references cited, if appropriate?	Choose an item.	
Are the references cited in full, if appropriate?	Choose an item.	
Are supporting documents cross referenced?	Choose an item.	

Title of document being reviewed	Yes or no	Comments
Has an equality impact assessment or full impact assessment been completed and reviewed as required?	Choose an item.	
If appropriate, does the policy use gender neutral language, and is the policy explicitly inclusive of same-sex couples?	Choose an item.	
If appropriate, does the policy clearly state that the organisation will not tolerate discrimination against employees on the grounds of sexual orientation or gender identity and/or trans identity. These may be listed along with other protected characteristics?	Choose an item.	
If appropriate, does the policy include guidance on facilities and dress code for non-binary people?	Choose an item.	
Does the document identify which committee will be asked to ratify it?	Choose an item.	
Is there an outline plan to identify how this will be done?	Choose an item.	
Does this include training or support to ensure compliance?	Choose an item.	
Is it clear whether the document can be published on the organisational website? If it cannot, is a clear, valid reason given for this?	Choose an item.	
Is a review date identified?	Choose an item.	
Is the frequency of review identified? If so, is it reasonable?	Choose an item.	
Is there a plan to review or audit compliance with the document?	Choose an item.	
Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Choose an item.	

Appendix 5: Consultation form

Please add any comments, sign on the last page and return this form. If you do not return this form, the assumption will be that you are satisfied with the content of the document.

This policy has been passed to the following people and groups for comment:

Name	Designation	Address
Enter name	Enter designation	Enter address

If you feel that this document should be passed to other colleagues and groups for their views then please write the names, job titles and contact addresses below. This could also include colleagues from outside the orgnaisation. The author will arrange for a copy of the document to be sent to them.

Name	Position	Address
Enter name	Enter position	Enter address

Comments

Please specify page and paragraph numbers or send back electronically with ‘tracked changes’ or comments.

Page or Paragraph	Comment
Number	Enter comment

Signed:

Appendix 6: Summary of consultation responses

Consultee	Response received (summary)	Changes made as result (or reason not made)
Enter consultee	Enter response received	Enter changes made