Classification: Official

Publication reference: PRN01939

# NHS Standard Contract 2025/26: A further consultation

## Proposed additional changes to the NHS Standard Contract for 2025/26

Version 1, April 2025

Prepared by: NHS Standard Contract team, NHS England
england.contractsengagement@nhs.net

# Contents

# Introduction

1. This consultation asks for views from stakeholders on further changes which NHS England proposes to make to the NHS Standard Contract for 2025/26.

2. The NHS Standard Contract (the Contract) is published by NHS England for use by NHS commissioners to contract for all healthcare services other than primary care services (unless these are commissioned using Schedule 2L (*Provisions Applicable to Primary Medical Services*)). A consultation was published in February this year on changes for 2025/26 to both versions of the Contract – the full-length version, which is used to commission the bulk of such services by value, and the shorter-form version, which can be used in defined circumstances for certain less complex and typically lower cost services. This consultation has now completed and the consultation response can be found here. As no further changes are planned to the Contract Particulars 2025/26, we have now published these on the NHS Standard Contract page. We are proposing further changes to the Service Conditions, General Conditions and Technical Guidance but have published interim 2025/26 versions of these which include the changes from our earlier consultation for your assistance. Once we publish the final version of the Service Conditions and General Conditions, these will be automatically incorporated into any signed contracts and no further action will be required from commissioners and providers.

3. Commissioners are encouraged to proceed now to use the Contract Particulars to complete their contracts for 25/26. As this consultation proposes changes to the Contract Activity Management provisions which may rely on the completion of a robust Indicative Activity Plan (IAP), we recommend that commissioners take time to ensure that the proposed IAP for each contract represents the activity that the commissioner needs to commission to achieve both its elective targets and its efficiency targets and to discuss each proposed IAP with the provider and other commissioners.

4. This consultation document describes further material changes that we are proposing to make to both versions of the Contract. We welcome comments from stakeholders on our proposals, along with any other suggestions for improvement. Comments on the draft Contracts can be submitted via the NHS England Consultation Hub using the online form.

5. We have also provided a standard template on the Further Consultation webpage to help stakeholders collate responses from across their organisation. Please note that responses can only be submitted using the online form via the NHS England Consultation Hub. Specific queries on the Contract may be sent to england.contractshelp@nhs.net.

6. **The deadline for receipt of responses is 28 April 2025. We will publish the final versions of the Contract Service Conditions, General Conditions (both full-length and shorter-form) and our Technical Guidance as soon as is possible after that. No further changes will be made to the Contract Particulars.**

# Proposed changes to Contract content

7. Material changes proposed to the Contract for 2025/26 (whether to the full-length version, the shorter-form version or both) are summarised in the table below.

8. In each case, the summary gives an overview of the change proposed – and points towards the sections of the draft Contract where the relevant wording can be found.

9. The topic numbers in the left-hand column in the tables below have been added to make it easier to 'read across' to the online feedback form available via the NHS England Consultation Hub. Numbers 1-6 are not used in this consultation document, as they correspond to stakeholders' name, email address etc on the online feedback form.

**Activity Management Provisions**

10. The NHS Payment Scheme for 2025/26 had proposed to introduce a Notified Payment Limit which would allow commissioners to limit payment on all contracts with a variable element to no more than the Notified Payment Limit. Following consideration of feedback received in the NHS Payment Scheme consultation, this proposal has been withdrawn.

11. To assist commissioners in the management of variable activity to deliver elective performance targets and balanced financial plans, we are proposing some amendments to the existing Contract Activity Management process. The proposed changes give commissioners greater control in the management of activity based on a Contract IAP.

12. The principal changes proposed are:
    a. that commissioners will be able to set an IAP if none has been agreed within 3 months of the Service Commencement Date
    b. that, having followed the Activity Management process set out in the Contract, if a commissioner and provider are unable to agree an Activity Management Plan (AMP), that commissioner will be able to set an AMP
    c. we will be including in guidance an additional escalation route to NHS England (or an independent panel where NHS England is the commissioner) for providers whose commissioners have set either an IAP or an AMP. This escalation process will be available where commissioners have not followed the guidance included in our Technical Guidance on setting a plan.

The table below sets out the detail of the changes we are proposing and we are publishing proposed versions of the Service Conditions and General Conditions which illustrate these changes. We are not at this point publishing a proposed new version of the Technical Guidance and we have instead set out the proposed changes in this document below.

| Topic | Change | New Contract Reference |
|---|---|---|
| 7) Indicative Activity Plan | So that variable activity is always delivered by reference to a plan, we propose amending the Service Conditions to require that an IAP is always agreed for a contract with activity paid for variably.<br><br>Similarly, we propose adding a provision that, if an IAP has not been agreed between the provider and the commissioner by three months after the Service Commencement Date, the commissioner may set an IAP. It remains the case that if a plan is not set or agreed then the IAP will be zero. | Service Condition 29.5 and 29.5 A-B (FL) and 29.3 and 29.3 A-B (SF) |
| 8) Activity Management Plan | The Contract currently provides a process for Activity Management which may culminate in the agreement of an AMP. So that an AMP can always be put in place where activity has exceeded an IAP, we propose amending SC29.13.2 to allow any commissioner to require an AMP. Similarly, we propose amending SC29.14 to say that, where provider and commissioner have failed to agree an AMP following the full process, any commissioner may set one.<br><br>We then also propose an amendment to the Definition of an AMP in the General Conditions, and to the payment provisions of the Service Conditions, so that a commissioner can always apply any financial consequences included in the AMP and can require providers to continue to accept referrals as required under patient choice whilst managing waiting lists in such a way as to stay within the IAP. | Service Conditions 29.13.2 and 29.14 (FL) and 29.6, 29.7 and 29.7A-D (SF)<br><br>Service Condition 36.1 (FL and SF)<br><br>Definitions |
| 9) Escalation Process | We are proposing the introduction of a new escalation route for providers where the commissioner has not acted in accordance with our guidance in setting an IAP or AMP. This route will act in addition to the normal Dispute Resolution processes set out in the General Conditions and will be available to all providers. | Service Conditions 29.16 A-C (FL) and 29.7E-G (SF)<br><br>Definitions |

## Guidance on use of new provisions

To clarify how these new provisions should be used, we propose to amend the guidance on *Managing activity and referrals* in our Contract Technical Guidance so that it will read as follows (changes to the existing wording are highlighted in yellow):

# 42 Managing activity and referrals

*The provisions in the **shorter-form Contract** for managing activity and referrals are very significantly simplified. There is the requirement to include an IAP for a contract with activity paid for variably, but no reference to Activity Planning Assumptions, as these would not generally be expected in relation to the types of service for which the shorter-form may be used. The Activity Management provisions in the shorter-form Contract have, however, been extended to align with the Full-length Contract.*

42.1 The key aims of the provisions in SC29 (Managing Activity and Referrals) are to ensure that:

- where patients have a legal right to choose their provider, this is always enabled;
- activity carried out under a contract is clinically appropriate and supports achievement of nationally set performance targets; and
- where an IAP has been agreed or determined at the start of the year, activity is managed within the levels set out in the plan or – where there are variances – these happen for agreed clinical or patient care reasons that are understood and accepted by the commissioner and provider.

42.2 There will be situations where it is appropriate for commissioners to use the provisions within SC29 to put downward pressure on activity levels within a contract and the contract permits commissioners to set an AMP which may be used to control activity to within the limits of the IAP. For further guidance on appropriate use of the contractual provisions on activity management, reporting requirements and payment arrangements, please refer to paragraph 42.34 onwards.

*Overall responsibilities for managing referrals and activity*

The Contract identifies that both the commissioner and the provider have responsibilities for managing referrals and activity.

- Commissioners (SC29.3) (SC29.1 in the shorter-form Contract) must seek to ensure that referrals comply with any agreed protocols and (full-length version only) any relevant Activity Planning Assumptions. In practice, the reasonable expectation will be that commissioners should be making vigorous efforts to ensure that GPs and other primary care referrers are following agreed protocols.
- Providers (SC29.4) (SC29.2 in the shorter-form Contract) must also seek to ensure that referrals comply with agreed protocols. They will bear a particular responsibility for managing referrals which are internally generated (consultant-to-consultant referrals, say), but may also

reasonably be expected to assist commissioners in ensuring that primary care referrals are in line with agreed protocols.

- Providers will also bear particular responsibility for ensuring that the decisions made by their clinical staff to provide treatment to patients are made in line with clinical thresholds set out the Contract or notified through Prior Approval Schemes. They must also seek to work within the Activity Planning Assumptions relating to referrals and other metrics and to endeavour to deliver activity in line with the IAP.

*42.3-42.19 omitted from this consultation paper as there is no change to these sections and they are not relevant to these changes. They can be viewed in the published guidance if required.*

*Indicative Activity Plan*

42.20 Prior to the start of the contract year, the parties should agree an IAP. This plan is an indication of the volume of activity that the commissioner wishes to commission to meet the needs of its population, the local waiting time targets that it has agreed in its system plan, and the level of activity that the commissioner can afford. Ideally, that volume will be estimated and agreed by the two parties but if it cannot be agreed within three months of the Service Commencement Date, the commissioner will have the right to set an IAP. An IAP can never be retrospective and can only deal with activity that it is to be carried out from the point that it is agreed or set. Where possible, consideration should be given to what activity is already scheduled to be carried out and cancelling notified appointments should be avoided. A commissioner can also seek to agree an IAP (or set one) with an NCA provider if activity reaches a level that may require activity management (as any NCA activity takes place under an implied contract on the terms of the qualifying contract (which must be in the form of the NHS Standard Contract)).

42.21 The IAP should include sufficient detail for all parties to understand the indicative activity that has been agreed and any thresholds for reporting purposes that are required by the commissioner. These thresholds should act as a trigger for discussion to understand why activity is over or under the indicative levels and to agree any necessary action to bring activity back in line with the IAP.

42.22 An IAP may reflect the expected impact of demographic changes and any firm trends in demand; it may also need to factor in requirements for additional non-recurrent activity to reduce waiting times so that waiting time standards – whether local or national - can be achieved. Equally, an IAP can reflect planned service expansions – or expected reductions in activity within a given service, because of commissioner development of other services elsewhere, or plans to improve referral practice, or plans to manage waiting times across commissioned providers. The net effect should be a realistic plan, shared between commissioner and provider, giving the provider sufficient confidence to put in place an agreed level of capacity to cope with the expected demand and achieve any agreed targets. Any IAP must reflect commissioner affordability and the requirement for the NHS to stay within planned expenditure levels.

42.23 The IAP, as the name suggests, is indicative. For a provider to provide more or less activity than is included within the IAP is not a breach of a contractual requirement, and the commissioner cannot withhold payment simply on this basis. However, having followed the Activity Management processes described below, a commissioner may, through the construction of an AMP, require a provider to plan its future activity in such a way as to align with the IAP for the full year and it may withhold payment as set out in the AMP.

42.24 Where activity planning discussions identify genuine limitations in capacity in a particular service at a provider, commissioners may need to seek to commission additional providers for patients to choose from – or look at whether, within the confines of Good Practice, more appropriate referral criteria for that service should be introduced. However, the underlying requirement within the Contract remains that providers will need to be able to manage their waiting lists as demand fluctuates, accepting referrals and treating patients in line with the IAP rather than turning them away.

42.25 An IAP should be agreed for all contracts which include services funded on a variable basis. Commissioners must take account of the following principles in constructing an IAP:

- Use reasonable endeavours to collaborate with other commissioners of the same contract to ensure that, where possible, activity plans support the provider in the management of a single waiting list (In the case of NCA activity, the commissioner will only usually need to communicate with the Co-ordinating Commissioner)
- Construct IAPs with regard to applicable provider waiting times targets set out in NHS priorities and planning guidance.
    - Commissioners should aim to commission activity across all providers in a way that efficiently uses available capacity to balance system affordability and performance requirements
    - Where this involves reducing commissioned activity this should be supported by analysis of demand, capacity and the impact on waiting times.
- Appropriately plan for clinically urgent activity such as abortion care, Cancer treatment and 111 calls ensuring that providers can respond to increases in demand without being limited by an IAP
- Consider and discuss with providers potential equalities and quality impacts of any IAP
- Take reasonable steps to agree an IAP with a provider before setting one.

IAP Escalation Process

42.26 If a commissioner and provider have been unable to agree an IAP and a commissioner has used its power to set an IAP, the provider, having followed the first stage of the Dispute Resolution process, may escalate concerns to NHS England where it can show that the commissioner has not followed the principles set out at 42.25:

- The provider must complete the Escalation Form contained at Appendix 5. The completed Escalation Form must be sent, by the

provider to the commissioner, within 10 working days of an IAP being set and notified by the commissioner
    - The commissioner must complete its section of the Escalation Form within 10 working days of receipt from the provider, and return it to the provider
    - The provider must send the completed combined Escalation Form to england.activityescalation@nhs.net at NHSE within 25 working days of an IAP being set and notified by the commissioner

- NHS England will review the Escalation Form and, if it considers that the criteria for escalation are met, it will either:
    - If the commissioner is an ICB, seek a response from the commissioner, consider the merits of the provider's case and either, recommend a change of action to the commissioner or, inform the provider that it considers the commissioner has acted appropriately in line with the guidance.
    - Or, if the commissioner is NHSE, then the case will be referred to a Cross-System Panel who will complete the consideration and either, recommend a change of action to the commissioner or, inform the provider that it considers the commissioner has acted appropriately within the guidance.

- If NHS England considers that the criteria for escalation are not met, it will inform the provider and the commissioner of its finding

- NHS England will use all reasonable endeavours to confirm whether an escalation will be permitted within 10 working days and to provide the outcome of an escalation within a further 20 working days.

- Should the provider be dissatisfied with the outcome of the above process, the usual processes for Dispute Resolution set out at General Condition 14 will still be available to them.

- While pursuing an escalation in relation to an IAP, the provider should continue to adhere to the IAP.

- In relation to any contract in any contract year, a provider may only apply once for escalation to NHS England on the setting of an IAP.

*Activity Planning Assumptions*

42.27 The commissioner may also wish to set Activity Planning Assumptions (APAs). These may include assumptions about the expected level of external demand for the Services to be provided under the specific contract and / or assumptions relating to how the particular provider will manage activity once a referral has been accepted. Adherence to APAs is monitored as part of the activity management process.

42.28 Whether or not to set APAs is a matter for the commissioner. APAs must be consistent with the IAP and should not be set in such a way that, as a result, a

provider cannot provide the Services in line with Good Practice or that patient choice of provider (where the legal right applies) is restricted. For multi-lateral contracts, commissioners should seek to have common APAs for all commissioners. Where this is not possible, the number of different APAs in the contract must be kept to a minimum.

42.29 SC29.7 makes clear that APAs are to be notified by the co-ordinating commissioner to the provider. The Contract provides a schedule (Schedule 2C) in which the notified APAs can be recorded, and we think that it is sensible that this schedule should be used as a matter of normal practice. However, for the avoidance of doubt, as the Contract definition of APAs makes clear, APAs are valid so long as they are properly notified to the provider in accordance with SC29.7, regardless of whether or not they are included in the local contract schedule. However, the definition also makes clear that APAs must be consistent with the relevant IAP. The effect is that:

- a commissioner can only notify APAs which align with the agreed IAP; and
- a provider cannot prevent properly notified APAs, consistent with the IAP, from taking contractual effect by refusing to include them in Schedule 2C.

42.30 APAs are likely to be used particularly for acute hospital services. To be effective, they should be measurable and evidence based. Potential APAs include:

- first to follow up outpatient ratios;
- average waiting times or minimum waiting times
- referrals by source (GP; other primary care provider; consultant-to-consultant; self-referral);
- emergency readmissions; and
- non-elective admissions as a proportion of A+E attendances.

42.31 The provider is under a contractual obligation to use all reasonable endeavours to manage activity in accordance with APAs, and the commissioner can use the processes set out in SC29 (AMPs, for instance) to ensure that this happens. Commissioners should act reasonably, however, in assessing providers' compliance with APAs, reflecting that APAs such as those listed in paragraph 42.29 above tend to be statistical constructs, giving indicative information about the way in which services are being delivered, rather than setting precise standards requiring precise compliance.

*Activity Query Notices*

42.32 On receipt of an activity report which indicates variances against the thresholds set out in the IAP, either party may issue an Activity Query Notice (AQN).

42.33 Where an AQN is received, the parties must meet to review referrals and activity and the exercise of patient choice. There are two possible outcomes of the meeting:

- the AQN is withdrawn; or
- a Joint Activity Review is held.

*Joint Activity Review and Activity Management Plan*

42.34 A Joint Activity Review will be used to identify the reasons for variances in activity and may result in an AMP being agreed. Where there is disagreement, either as to whether an AMP is required or as to the actions which it should set out, the commissioner may set an AMP.

42.35 The AMP may include agreements on how activity should be managed for the remainder of the contract period. The plan should not restrict patient choice ofp. Where it is found that the provider's actions have been causing increased internal demand for services, for example by reducing clinical thresholds, changing clinical pathways or introducing new services without the agreement of the commissioner, the plan may include an immediate consequence of non-payment for that activity. The AMP may also include financial consequences for not adhering to the plan eg if the plan requires a reduction in activity and activity is not reduced, the consequence could be that a commissioner will not pay for that activity. This should be clearly set out in the plan.

42.36 Any AMP will usually include:

- details of the IAP/APA threshold that has not been met including a breakdown of actual activity, actual cost of activity (where appropriate) and actual variance; and
- evidence of review of the activity, including source data (waiting lists, interviews, sample of patient notes, clinical process and patient flow) and analysis of the likely causes of any breach.

42.37 Beyond that, depending on the particular situation, an AMP may set out

- provider-specific actions to improve the management of internal demand, to align its activity to the full year level of the IAP, to improve its utilisation of existing capacity and resources, or to expand capacity – and timescales for those actions to be completed;
- commissioner-specific actions to manage external demand and timescales for those actions to be completed; and/or
- any proportionate financial consequences where actions are not completed on time, including not funding activity carried out above the IAP.

42.38 Commissioners must take account of the following principles in setting an AMP:

- Use reasonable endeavours to collaborate with other commissioners of the same contract to ensure that, where possible, AMPs for a single provider are consistent with provider management of a single waiting list. (In the case of NCA activity, the commissioner will only usually need to communicate with the Co-ordinating Commissioner)
  - Commissioners may use an AMP to reduce activity to the levels set out in the IAP and to the levels required to meet system performance and affordability targets, as agreed within the annual planning discussions. In doing this, they should be able to show that they have considered demand, capacity, performance and activity across their system.
- Appropriately plan for clinically urgent activity such as abortion care, Cancer treatment and 111 calls and ensure providers are able to respond to increases in demand without being limited by an AMP
- Act in a timely way to manage any overperformance against an IAP, ensuring that the provider has time to react to and correct any overperformance via an AMP. It is expected that over-performance issues would be addressed at regular monthly contract meetings with providers.
- Follow the contractual process to agree an AMP with the provider before setting a plan.

42.39 The table below gives more detailed examples of the ways in which an AMP can be used to address a specific situation.

| **Issue** | **Potential actions in an AMP include:** |
|---|---|
| Increase in provider capacity reducing wait times and increasing activity | • Provider reduces activity to align with plan and commissioner confirms expected waiting times targets |
| GP referrals driving increase in elective Activity (above IAP) at provider | • Commissioner reviews adherence by GPs to agreed protocols / thresholds – and may consider introducing tighter ones.<br>• Commissioner reviews process for offering patients choice of provider – i.e. to ensure that full range of options are discussed with patients.<br>• Provider, by agreement with commissioner, increases waiting times to reduce level of activity to align with IAP. |
| Activity exceeds IAP because of increase in provider “decisions to treat” for an elective procedure (above APA) | • Provider arranges internal review of clinical practice by consultants, aimed at ensuring adherence to agreed treatment guidelines.<br>• Commissioner notifies and implements a new / revised Prior Approval Scheme. |

| | |
|---|---|
| Activity exceeds IAP because of increase in follow-up ratio in a particular specialty (above APA) | • Commissioner undertakes to promote better use of existing shared care arrangements, so that more follow-up is arranged in primary care.<br>• Provider agrees to implement measures to ensure hospital follow-up is only offered where strictly necessary / expand its implementation of patient-initiated follow-up. |
| Referrals at expected level, but Activity below IAP and waits increasing | • Provider takes action to improve its internal productivity / efficiency so that more Activity can be delivered.<br>• Provider agrees to place a new sub-contract with another provider for additional capacity. |
| Activity exceeds IAP because referrals to the provider are being made by GPs to the provider direct, rather than (as intended) via the ICB's triage service | • Commissioner engages with GPs to promote the benefits of the triage approach and encourage use, focussing on those practices which are not aware of / using the triage service.<br>• Potentially, provider starts to return clinically inappropriate referrals to GPs or redirect them to the triage service, rather than accepting them. |

42.40 In extreme situations, where a provider is unable to cope safely with the flow of new referrals into a particular service, discussions under SC29 may lead the commissioner to suspend (under GC16) all new (or all non-urgent) referrals into that service for a time-limited period. See paragraph 25.20 above for more detail on this and paragraphs 47.11-13 below for more information about the suspension provisions. Note that suspension can only be initiated by the commissioner. A provider can only properly close a service, without commissioner agreement, as part of an Incident Response under SC30. For this to apply, the clinical risks associated with continuing to accept referrals and provide treatment would have to be very significant.

AMP Escalation Process

42.41 If a commissioner and provider have not been able to agree an AMP and a commissioner has used its power to set an AMP, and if the provider can demonstrate that the commissioner has not followed the principles set out at 42.37, the provider, having followed the first stage of the Dispute Resolution process, may escalate the issue using one of the following routes:

- The provider must complete the Escalation Form contained at Appendix 5
- The completed Escalation Form should be sent, by the provider to the commissioner, within 10 working days of an AMP being set and notified by the commissioner
- The commissioner must complete its section of the Escalation Form within 10 working days of receipt from the provider, so that
- The provider can send the completed combined Escalation Form to england.activityescalation@nhs.net at NHS England within 25 working days of an IAP being set and notified by the commissioner

- NHS England will then review the Escalation Form and, if it considers that the criteria for escalation are met, it will either:
    - If the commissioner is an ICB, seek a response from the commissioner, consider the merits of the provider's case and either, recommend a change of action to the commissioner or, inform the provider that it considers the commissioner has acted appropriately within the guidance.
    - Or, if the commissioner is NHS England, then the case will be referred to a Cross-System Panel who will complete the consideration and either, recommend a change of action to the commissioner or, inform the provider that it considers the commissioner has acted appropriately within the guidance.

- If NHS England considers that the criteria for escalation are not met, the form will be returned to the provider with that communication.

- NHS England will use reasonable endeavours to confirm whether an escalation will be permitted within 10 working days and to provide the outcome of an escalation within a further 20 working days.

- Should the provider be dissatisfied with the outcome of the above process, the usual processes for Dispute Resolution set out at General Condition 14 will still be available to them.

- While pursuing an escalation in relation to an AMP, the provider should continue to adhere to the AMP.

- In relation to any contract in any contract year, a provider may only apply once for escalation to NHS England on the setting of an AMP.

*Financial consequences under SC29*

42.42 It is evident from the queries we receive that there is some misunderstanding about the ability of a commissioner to withhold funding from a provider under SC29. Clarification is set out below.

42.43 Exceeding the level of activity described in the IAP or breaching a ratio (or similar) set in an APA does not create an automatic entitlement for the commissioner to withhold funding. Rather, the contractual requirement is for an AQN to be served and an Activity Management Meeting to take place, followed by agreement and implementation of an AMP where indicated. By agreement, an AMP may include financial consequences (on either party) for failing to implement the actions set out in the AMP, but the primary purpose of the AMP (as made clear in the Contract definition) is to "restore levels of Referrals and/or Activity to within agreed thresholds" eg in line with the IAP.

42.44 More broadly, failure by the provider to comply with its SC29 obligations may properly lead a commissioner to:

- pursue remedy under the GC9 contract management process (which may ultimately result in withholding of funding – see paragraph 45 of this Guidance); or

- seek to apply the provisions of GC11.2 (indemnity for losses incurred as a result of the provider's breach of contract – see paragraph 47.32 onwards).

42.45 Equally, a provider's response to an AQN may prompt the commissioner to contest payment under SC36.30 (see section 46), either because of simple inaccuracy or because of failure to notify a locally-proposed change in the counting and coding of activity under SC28 (see section 44).

42.46 The only ways, however, in which a commissioner can properly withhold funding directly under SC29 are:

- to apply a financial consequence included in an AMP (SC29.16); or

- to withhold payment for activity carried out in contravention of the terms of a duly notified Prior Approval Scheme (SC29.18).

# Consultation Responses

13. We invite you to review this consultation document and the draft Service Conditions and General Conditions (available on the Further Consultation webpage) and provide feedback on any of our proposals.

14. Comments can be submitted only via the NHS England engagement portal through the online feedback form. We have published a standard template on the Further Consultations webpage to help stakeholders collate responses from across their organisation. This document should not be used to submit responses by email, and all responses should be submitted via the online form. Specific queries on the Contract may be sent to england.contractshelp@nhs.net.

15. **The deadline for receipt of responses is 28 April 2025. We will publish the final versions of the Contract Service Conditions and General Conditions (both full-length and shorter-form) and update our Technical Guidance as soon as is possible after that. The final 2025/26 Particulars are already published on the NHS Standard Contract webpage.**

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: enquiries@england.nhs.uk

This publication can be made available in alternative formats on request