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2025/26 NHS Standard Contract

Further consultation - summary of key changes made in response to consultation feedback

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Introduction

Following our further consultation on the NHS Standard Contract 2025/26 which ended on 28 April 2025, NHS England has now published the final NHS Standard Service Conditions and General Conditions for 2025/26 here.

We recognise that the Contract is being published late in the financial year and we encourage commissioners to complete contracts as promptly as possible from this point. In recognition, we have amended the deadlines for contract signature and escalation previously published in the Revenue Finance and Contracting Guidance.

The deadline for signature of all contracts is now 29th May and any contracts not signed by that deadline should be escalated to NHS England Regional teams. Contracts not signed by 4th July will be escalated for national arbitration. There is guidance at paragraph 24 of our Contract Technical Guidance on the position where contracts are unsigned. Additional guidance was shared with ICBs in early March advising the extension of any contracts which form qualifying contracts for the purpose of patient choice.

This Consultation Response document describes the material changes we have made in the final full-length Contract in response to stakeholder feedback received during this second consultation process. Changes have been carried over to the shorter-form version of the Contract where relevant.

Overall consultation feedback

We received feedback from 126 organisations or individuals in relation to the specific changes we proposed to the interim 2025/26 Contract. 59% of responses received were from providers, and 28% from Integrated Care Boards and Commissioning Support Units together.

Each of the proposed changes had majority support, and in most cases we have retained in the final Contract the wording proposed in the draft version. In a small number of areas, consultation feedback has prompted us to make changes in the final version of the Contract. In other cases, the feedback indicates that, whilst the specific proposed changes to the Contract are supported, further clarification as to their rationale and intent would be helpful.

Our detailed response is set out, issue by issue, below. Issues that are not listed below were considered but no changes were required. Please note that percentage responses relate to those answering ‘yes’ or ‘no’ only, ‘not applicable’ responses have been omitted.

Changes in response to feedback

Indicative Activity Plan (IAP)

We proposed changes to allow any commissioner to set an Indicative Activity Plan where one cannot be agreed between commissioner and provider. 63% of respondents supported this proposal. We therefore intend to adopt this change.

In response to feedback and to clarify the scope, we have amended the definitions in the General Conditions to include the following:

> **Services Paid for on an Activity Basis** services which are funded by a price being paid per unit of activity (or pathway) delivered rather than by a block payment

We have also amended the Service Conditions to include the above term.

To respond to feedback, we have made some minor amendments to the Technical Guidance to better explain the application of this change. Specifically, we have:

- Emphasised the requirement for commissioners to consult and collaborate with each other when agreeing and setting plans for a provider and to consider the provider impacts of different plans.
- Further clarified that, as the requirement to set an Indicative Activity Plan only applies to services that are paid for an activity basis, Low Volume Activity (LVA) arrangements, which are paid in block, are not in scope of these proposals.
- Reviewed and emphasised commissioner responsibilities for referral and demand management.
- Added to the requirement for commissioners to consider quality and equality impacts to clarify that this includes patient safety and patient experience.
- Added further guidance on the application of an IAP to Non-Contract Activity which is paid variably (i.e. not LVA) and to unsigned contracts.

We received some comments about the timing of setting an Indicative Activity Plan - some felt that it was too late and others that it was too soon. We have retained the date of 30 June or 3 months after Service Commencement Date in recognition of the delayed publication of the final Contract this year. We expect commissioners and providers, wherever possible, to agree an Indicative Activity Plan before that date. When we consult on the 2026/27 Contract, we will include a proposal to bring this date forward in the contract year.

Respondents commented on the challenge of balancing affordability and meeting performance targets. We expect commissioners and NHS trusts to have worked through this as part of the development of their 2025/26 operational and financial plans. These plans should be reflected in IAPs.

Some providers asked that we make changes to the IAP guidance to limit the types of plans that ICBs can set, including a requirement that plans are not be set below prior year activity levels. Such constraints could undermine commissioner and provider efforts to balance affordability with meeting performance targets, as well as

agreed 2025/26 operational and financial plans. As the guidance was supported by a majority of respondents, we have decided not to make it more restrictive.

Activity Management Plan (AMP)

We proposed changes to allow any commissioner to set an Activity Management Plan where one cannot be agreed between commissioner and provider. 51% of respondents supported this proposal. We therefore intend to adopt this change.

It was our intention in making the Contract changes to allow any commissioner to initiate an Activity Query process and agree an AMP. It has been pointed out that some terms of the Service Conditions at 29.10-13 still refer to the Co-ordinating Commissioner. We have made amendments to make it clear that any commissioner can initiate these processes with a requirement that they notify the co-ordinating commissioner when they do so. Wherever possible, commissioners should collaborate in setting a management plan for activity that relates to the same contract. We have updated the Technical Guidance to make this clear.

Some providers commented that the proposals felt unilateral and did not require action from commissioners to control demand. As noted under Indicative Activity Plans, we have reviewed and clarified commissioner responsibilities for referral and demand management and for transformation of activity delivery.

Some respondents commented that the existing Activity Management process is too complicated and takes too long, and they asked for it to be simplified. We have reviewed the process and decided not to change it at present – the process needs to strike a balance between timeliness and allowing all parties to reflect on and analyse the position. If it were shortened it could undermine the consultative nature of the process and make it less equitable for providers.

Further guidance and support in the construction of Activity Management Plans was requested by commissioners. In addition to commissioner workshops on Indicative Activity Plans, which will be held in May, we will also run workshops on Activity Management Plans during the summer.

Concerns that a patient's right to choose a provider could be impacted by an Activity Management Plan were raised by some respondents. We reiterate that nothing in this proposal restricts a patient's ability to choose, or to request a referral to, any qualified provider. Where activity is managed by an Activity Management Plan, in a few cases there could be an impact on the time that a patient might have to wait for treatment and providers should manage this, as they already do, through the maintenance of patient waiting lists. We have added to the criteria for constructing an Activity Management Plan that commissioners must consider the impact on patient safety and experience of their plans.

In response to feedback, we have made some minor amendments to the Technical Guidance to better explain the application of this change. Specifically, we have:

- Emphasised the requirement for commissioners to consult and collaborate with each other when agreeing and setting plans for a provider and to consider the provider impacts of different plans.
- Further clarified that as the requirement to set an Indicative Activity Plan only applies to services that are paid for an activity basis, Low Volume Activity

(LVA) arrangements, which are paid in block, are not in scope of these Activity Management proposals.

- Reviewed and clarified commissioner responsibilities for referral and demand management.
- Added to the requirement for commissioners to consider equality and quality impacts that they should also consider patient safety and patient experience.
- Added further guidance on the application of an AMP to Non-Contract Activity which is paid variably (i.e. not LVA) and to unsigned contracts.
- Added to the guidance that commissioners should consider, before initiating an Activity Management process, whether variances to the IAP are material and likely to continue.

Escalation Process

We proposed changes to provide an escalation route for providers where commissioners had set an IAP or AMP without following our guidance. 60% of respondents supported this proposal. We therefore intend to adopt this change.

In response to feedback on timing and complexity, we have reviewed the timing of the escalation process and the relationship between the escalation process and the Contract Dispute Resolution processes and made the following changes:

- We no longer require that providers and commissioners complete the first stage of the Dispute Resolution process before providers initiate an escalation. Instead, we have emphasised that all avenues to agree a resolution with a commissioner, including internal escalation, should have been exhausted before an escalation is initiated through this process.

- We have reduced the window during which NHS England should complete a review of any escalation to 20 days in total (including the 10 day window to confirm if an escalation has been accepted). If the volume of escalations significantly exceeds expectations we may need to review this in year.

- In error, we had left in the guidance a requirement for NHS England to consult the commissioner, after we had instead added a requirement that commissioners should complete the form. We have removed this so that commissioners only input once to the process as intended.

- We were asked if the outcome of the escalation process would be binding on the parties. We have clarified in the guidance that SC29.16 makes the outcome of the process form a contractual obligation on the commissioner if the commissioner is required to change their position. Both parties can hold each other to account for breaches of contract as applicable.

- We considered feedback requesting that the escalation process should prevent any further opportunity of challenge. We believe it would not be appropriate to remove further access to the Dispute Resolution process at General Condition 14. We are however altering the wording to make clear

that disputes would enter the process at a later stage if an escalation had already taken place.

- We have amended our wording on the number of times escalation can occur to make clear that escalation for each IAP or AMP is limited to once per commissioner/provider contractual relationship and not per whole contract.

- We have included the Escalation Form as an appendix to the Technical Guidance. Those who felt it should have been part of the consultation will hopefully agree that, as it simply reflects the terms consulted on, it would not have added value at that point.

- We have made minor amends to the wording to make clear that, while escalated, an IAP applies but is still indicative in the usual way.

- Finally, we were asked what would happen if either party did not meet the required timescales for submission of an escalation. We have amended the Technical Guidance to make clear that, if a provider misses the deadline for sending the form to the commissioner, no escalation will be available to them. If a commissioner does not complete the form within the required timeframe then the provider may escalate without the commissioner's view being included in the escalation.

Support and Webinars

Through the consultation, some respondents raised the issue of capacity to deal with these processes, particularly in the context of the reductions required in administrative staff in ICBs and Trusts. In the recent communication on changes - NHS England » Working together in 2025/26 to lay the foundations for reform, it was noted that ICBs should maintain or invest in core finance and contracting functions in the immediate term, and invest in strategic commissioning functions including contracting. NHS England will be providing workshops for commissioners in May to discuss the construction of Indicative Activity Plans, followed by further workshops in July/August on the use of Activity Management Plans.

Our ContractsHelp inbox is available for queries and support on all of these topics and we will do our best to help commissioners and providers to navigate these changes.

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