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2026/27 NHS Standard Contract

Summary of key changes made in response to consultation feedback

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Introduction

Following our consultation on the NHS Standard Contract which ended on 16 December 2025, NHS England has now published the updated NHS Standard Contract Particulars, Service Conditions and General Conditions for 2026/27.

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

Overall consultation feedback

We received feedback from 145 organisations or individuals in relation to the specific changes we proposed in the draft 2026/27 Contract. Most responses received were from providers (74%); Integrated Care Boards and Commissioning Support Units accounted for 14% of responses.

Most of the proposed changes had majority support[1], so 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.

Changes in response to feedback

The numbering in the table below is taken from the consultation paper published alongside the draft Contract.

7	National Quality Requirements - Cancer and Urgent Care 96% of those responding supported the alignment of these metrics with the targets published in the Medium Term Planning Framework. However, we received feedback that the Category 2 ambulance response times target was expressed as an end-of-year target when in fact this is a full-year target, so we have removed the end of year date. Additionally, it was raised that the ambulance handover targets set out in

[1] Throughout this document, where we quote a percentage of respondents to our consultation who either supported or opposed a particular proposal, the percentage stated is the proportion excluding any respondents who marked that particular proposal as “not applicable” in their response.

	Annex A are no longer current and so these have been removed and replaced with the target – as set out in the Urgent and Emergency Care Plan - to meet the maximum 15-minute handover standard. As some providers are currently not close to these targets, through the planning round individual improvement targets will be agreed with NHS England. We have therefore added these 2 metrics (Category 2 responses and Ambulance Handovers) to the group of metrics described in paragraph 9 below for which a provider-specific target must be included in the Local Quality Requirements, if one was agreed with NHS England during the planning round and this target will then override the national one.
8	National Quality Requirements - Talking Therapies 90% of those responding agreed with our proposal to add two Talking Therapies targets to the contract to align with those set out in the Medium Term Planning Framework. However, it was pointed out that the targets we included did not align with those in the final framework and therefore we have updated them to reflect those published.
9	Local Quality Requirements Our proposal to allow localisation of a small number of national targets to align with targets agreed with NHS England during the annual planning round (and only in those circumstances) was supported by 90% of respondents and these changes will be adopted. We have added Category 2 responses and Ambulance Handovers to these metrics to align with the planning approach. Some respondents questioned whether these metrics set out in the Particulars could override the Service Conditions Annex A as the usual hierarchy of precedence is General Conditions over Service Conditions over Particulars. We explained in the Consultation document that we have added a note to Annex A of the Service Conditions to give precedence to applicable targets in the Particulars and also clarified at Service Condition 3.1.1 that, for these metrics only, a target set out in the Local Quality Requirements would take precedence over Annex A. Community Waiting Times The Medium Term Planning Framework includes a requirement for ICBs to achieve a target of 78% of waits for Community Health Services being under 18 weeks. As this target is at ICB-level, we haven't included a provider-level target in the Contract. We strongly recommend, however, that all commissioners of community health services, agree a target with each provider for inclusion in the Local Quality Requirements of their contract. These provider-level targets should align to support achievement of the system-level target. Further information on Community Health Services waiting times can be found here: Statistics » Community health services waiting lists. A suggested metric definition is included in our Technical Guidance at paragraph 39.12.

10	Equality Act 2010 Our proposal to include the new proactive preventive duty on sexual harassment at Section 40A was supported by 100% of respondents with strongly supportive comments, and these changes have been included in the final Contract.
11	Health Inequalities Action Plan Our proposed update of the schedule to include new links to appropriate resources was supported by 98% of respondents. Some respondents felt that the schedule should be mandatory rather than optional. We have not made this change for this year as we did not consult on it, but will consider whether we should include it in our proposals for 2027/28. In the meantime, we continue to strongly recommend that commissioners and providers complete this schedule and monitor achievement of plans to support action on health inequalities in their system.
12	Martha's Rule 97% of respondents supported our new requirement to implement the three core requirements of Martha's Rule by 31 March 2027. At present the provisions of Martha's Rule apply only to NHS acute trusts but we were asked by respondents whether they might be extended to non-NHS and Mental Health providers. The application of the rule is currently being tests in Mental Health trusts, and we may chose to implement it in future years once testing is complete. No consideration has yet been given to extending the rule beyond NHS Trusts.
13	System Collaboration Our proposed amendment to the provision at Service Condition 4.7 on System Collaboration was supported by 94% of respondents. A number of respondents asked why the provision did not also apply to independent sector providers. We considered this, but felt that it was not reasonable to apply shared requirements around financial stabilisation to commercial providers. We would point out though that the remaining requirements of Service Condition 4 (*Collaboration*), do all apply to all providers so there is still a strong requirement to collaborate with each other and, at SC4.6, across their system, for all providers including non-NHS organisations.
14	Outlier Management 93% of respondents supported this proposal. We received some comments on the introduction of the new requirement when guidance on outlier management was not yet fully developed and we noted these. However, until guidance is published there will no requirement to comply with it and once published any queries on new guidance can be sent to

	the policy team at england.clinical-audit@nhs.net, so we have retained this proposed addition.
15	Antimicrobial Usage 97% of respondents supported our proposals to update the Contract to reflect the targets set out in the National Action Plan for Antimicrobial Resistance and therefore these have been included as proposed.
16	Local Policies Our proposal to review the wording on Local Policies at Service Condition 25.1-2 was supported by 66% of respondents. However, on reviewing the feedback we received, we agree that there could be broader implications of this clause that were unintended when we redrafted it. For example, some policies could apply on notification which it would have been more appropriate for the parties to discuss and agree. We are therefore proposing to revert to the previous wording of this Service Condition. Commissioners who supported the change should note that commissioner policies may still apply to the Contract on notification if they are Prior Approval policies, as set out in the Contract and explained in our Technical Guidance.
17	Contract Management Our proposal to make a range of changes to simplify the Contract Management processes was supported by 67% of respondents. We received feedback on a variety of aspects of our proposals as follows: - Comments were made that the ability for the commissioner to set a meeting for failure to engage at General Condition 9.5 was one-sided and unfair to providers. We accept this point and have made an amendment to apply this term to both parties. There were comments about one-sidedness at other stages of the process but as these related to parts of the process which lead to the application of financial remedies to the provider only, we feel that these need to remain as they are. - A number of respondents questioned what unreasonable would mean in this context and we have decided to remove this provision and allow a meeting to be set only for failure to engage by either party which simplifies the application of this clause. - Some respondents queried the increase of the failure to engage remedy at GC9.8 from 2% to 10% of contract value and did not seem to be aware that 10% was already the remedy level for contract breach at GC9.14.3. We chose to align the two to remove a perverse incentive not to engage in order to avoid the larger remedy level which could apply by following the process.

	- Others fed back that the process remained too long-winded but without proposing any specific ways in which further changes could be made – we are open to receiving suggestions on how we can improve these provisions in future years so do please continue to feedback on your experiences of using them.
18 19	SDIP - UK Standard for Microbiology Investigations SDIP - C. difficile infection ascertainment 96 and 95% of respondents supported these two SDIP proposals respectively. For the small number of Trusts who had concerns about achieving the SDIPs, we would remind you that use of these SDIPs is optional and should particularly be employed by ICBs where current compliance is not good and ICBs and providers can work together to agree an SDIP to overcome obstacles.
20	Data Quality Improvement Plan (DQIP) – flex and freeze data Our proposal to introduce a target for variance between flex and freeze data and an associated DQIP to support providers in working towards compliance was rejected by 59% of respondents, with 63% of providers rejecting the proposals. We have reviewed and considered the feedback and note a wide variance in feedback from providers – with some providers confident of compliance and others currently achieving levels very far below the targets. We note the comments around the difficulty of training, recruiting and retaining clinical coding resource but wonder if it might be useful to providers to focus on this via a DQIP. In recognition of the feedback but also recognising the importance of improving the timeliness of data, we propose to reduce the target requirement from 2% variance to 5%, with the intention of increasing to the higher level target in 2027/28. We were also asked a number of clarification questions around how compliance would be monitored. Providers and commissioners will find the Casemix and Clinical Coding Assurance Report, which covers the measures needed, useful. Indicator DQ01 and DQ02 cover number of records submitted and coding accuracy respectively and align with the Contract requirement. The report is published on FutureNHS in the Commissioning Data Sets – Data Quality Dashboards workspace found here: https://future.nhs.uk/commissioningdatasets/groupHome. More information on these dashboards can be also found here: https://digital.nhs.uk/services/secondary-uses-service-sus/cds-data-quality-dashboards. We will add these references to the Technical Guidance for future use.

21	Violence Prevention and Reduction Standard Our proposal to make implementation of the Violence Prevention and Reduction Standard mandatory for NHS providers was supported by 99% of respondents and we will adopt this change.
22	Safeguarding Children and Adults 100% of respondents supported our minor amendments to Service Condition 32.1 to increase the requirement to proactively take steps to prevent abuse so these amendments have been adopted with a minor amendment for readability.
23	Mental Capacity Act (MCA) – Learning Disability Our proposal to introduce a new requirement on providers of acute care to comply with the guidance on the implementation of MCA that NHS England published in June 2025 at NHS England » Guidance to support implementation of the Mental Capacity Act in providers of acute care for adults with a learning disability was supported by 96% of respondents. A small number of respondents suggested that it would be useful to put a Service Development Improvement Plan (SDIP) in place to work towards compliance with the national guidance. We are not proposing to provide an SDIP template for this but ICBs and providers are, of course, able to construct their own local SDIP to achieve compliance if they feel it is necessary to do so. It should be noted as well that whilst this new proposal was in response to specific feedback from the HSSIB recommendation about care of people with a learning disability in hospital, the requirement on providers to comply with the MCA as set out in Service Condition 32.3 applies to all adults in acute care whose capacity may be in doubt and not just those with a learning disability. Some providers did question whether it could be an option for providers to develop, or continue to use, their own MCA forms locally. However, the national team consider that a unified form is of considerable benefit to those who may change jobs across Trusts or work across more than one Trust and it provides a single standard which has been fully reviewed by national legal teams. We received a comment about inaccuracies in the guidance which gave no specific detail about what they were. If anyone would like to feedback on any specific points of the guidance, please email the LeDeR inbox at england.learning.disability.autism@nhs.net.
24	Nitrous Oxide Toolkit Our proposal to amend the terms of Service Condition 18.3.2.3 to reflect the publication of the Nitrous Oxide Toolkit was supported by 99% of respondents and the amendment will be included.

25	Capital Investment 95% of respondents supported our proposal to add a new requirement for NHS Trusts and Foundation Trusts to deliver the allocated capital investment. We received some questions around how this clause relates to internal versus external sources of capital investment. NHS England acknowledges the importance of ensuring clarity and confidence in the delivery of capital investment for decarbonisation. This clause ensures that trusts deliver the nationally allocated capital for decarbonisation from sources such as the Public Sector Decarbonisation Scheme, Great British Energy and NHS Solar Partnership, the Office for Zero Emission Vehicles, and other government sources, and develop business cases for future investment from other sources where appropriate.
26	Aligned Payment and Incentive Changes 80% of respondents supported our proposed changes to the layout of Schedule 3A to reflect the changes proposed in the NHS Payment Scheme consultation. It now looks as if the final Payment Scheme will be published at a later date than the final Contract. In order not to prejudge the outcome of the Payment Scheme consultation therefore, we are withdrawing these proposed changes from the Contract and have simplified the content of Schedule 3A. Instead, guidance on the completion of Schedule 3A will be published as part of the final Payment Scheme consultation. It should be noted that those not supporting the changes we proposed were generally commenting on the Payment Scheme rather than the Contract format which is what we were consulting on; we won't respond to those comments here, as a separate consultation was run on the Payment Scheme.
27	Indicative Activity Plans We were consulting on some minor changes to the Contract provisions on Indicative Activity Plans – to amend the date on which a plan can be set, and to allow a plan to be set in segments. 54% of respondents supported our proposed changes. However, many of the comments we received, in particular from those not supporting the changes, did not relate to the changes we were consulting on but instead to the general principle of setting Indicative Activity Plans. We did review all of these comments but they did not raise new points by comparison with the points raised in our consultation for the 2025/26 Contract when these new powers were introduced. We continue to consider that the powers to set Indicative Activity Plans provide valuable levers to ICBs in managing their achievement of performance and finance targets across multiple organisations and we would encourage all providers to work with ICBs to support those objectives wherever possible.

	On the points we were consulting on, the change of date appeared to be accepted by the majority, given the earlier publication of the Contract this year. Only a small number felt that a later date would be useful in giving more time to reach agreement on a plan – we would encourage those providers to reach out now to their ICBs to begin an early dialogue with a view to agreeing. The feedback received on allowing a plan to be set in parts made valid points around the risk of allowing plan setting to run on for long periods, creating a fragmented approach and leading to multiple disputes and escalations. We have therefore decided to withdraw this proposal and continue to require the full IAP for each commissioner to be set at one time.
28	Activity Management Processes Our consultation proposed a shortening of the timeframe for activity management and a clarification of the position if providers do not engage with the process. We note some comments that allowing commissioners to set a plan immediately after the Joint Activity Review meeting may encourage some commissioners to approach the meeting without a plan already in mind and without the intention of investigating and agreeing a position collaboratively. As we also had some strong support for this simplification, we propose to retain this amendment but we would like to emphasise to both parties that the purpose of a Joint Activity Review meeting is to collectively and collaboratively review the position, consider data and attempt to agree actions (potentially on both sides) to correct the position. The meeting should always be approached in this way and both parties should take time after the meeting to reflect on an appropriate plan.
29	Escalation Procedure Having introduced this Escalation Procedure in 2025/26 to support providers with the new IAP and AMP setting powers given to commissioners, we proposed removing it for 2026/27 now that the powers should be better understood by all parties. However, 51% of respondents rejected the proposal. The reasons for rejection fell into 3 broad categories: - ICBs felt that the escalation process had been supportive to them in introducing their new powers. - NHS Trusts had not generally used the process – as a different escalation process exists for NHS contract disputes - but felt that it might be helpful to them in the future. - Independent Sector providers felt that the process was flawed but wanted it to be retained with amendments to cover patient choice and performance impact of plans.

	In response to this feedback and to ensure that both commissioners and providers are supported to effectively use the IAP and AMP processes, we have decided to continue to offer the escalation process for 2026/27. However, as the process has been resource-intensive to run – in total 115 IAP escalations and 15 AMP escalations have been received to date – and all parties involved have used considerable resource in completing or arbitrating them, whilst we are going to continue the process for a further year in response to feedback, we are going to take time to consider whether the process could be made less resource-intensive. We may publish further guidance on the process in due course. We must note, however, that we will not widen the process to consider patient choice matters as these are already dealt with elsewhere. Details of how to complain or seek advice about matters relating to Choice, and about NHS England's role are published in our Patient Choice Guidance. The performance impact at an individual provider is also not considered as part of the escalation process as ICBs are required to manage performance across their system as a whole and are best placed to understand the contribution of each provider and the necessary steps to achieve performance and financial targets at a system level. We will not therefore be expanding the process or significantly altering the criteria for escalation. ICBs' system plans are, however, separately monitored and governed by NHS England. Please note that we have further updated our Technical Guidance at paragraph 42.27 to respond to some common points raised at escalation.

Other minor changes

The minor changes we proposed in our consultation have been adopted in full following supportive feedback. We have made the following further minor changes.

Core Skills Training Framework

We included in our consultation a proposal to remove the reference at General Condition 5.5.3 to the Core Skills Training Framework and replace it with the All Staff Core Competency Framework. It is now likely that this new framework will not be published until after the Contract is finalised and will be known as the NHS Competencies for All framework. We've therefore removed our proposed changes and instead added a note to the definition of Core Skills Training Framework to make clear that these provisions will apply to any successor framework.

Sepsis

New NICE guidance was published in November 2025 on antibiotic treatment for patients screening positive for sepsis. This guidance differs from the previous contract requirement and states:

1.8.3 Give people aged 16 or over who are at high risk of severe illness or death from sepsis broad-spectrum intravenous antibiotic treatment, within 1 hour of calculating the person's NEWS2 score on initial assessment in the emergency department or on ward deterioration.

The NICE Guideline also states:

1.8.1 A person is at high risk of severe illness or death from sepsis if they have suspected or confirmed infection and a NEWS2 score of 7 or above.

A person is also at high risk of severe illness or death from sepsis if they have suspected or confirmed infection, a NEWS2 score below 7, and:

- a single parameter contributes 3 points to their NEWS2 score and a medical review has confirmed that they are at high risk (see recommendation 1.6.2 on evaluating risk of severe illness or death from sepsis); or
- there are any other clinical reasons for concern (see recommendations 1.6.3 and 1.6.4 on taking causes for clinical concern into account when evaluating risk of severe illness or death from sepsis).

We have therefore amended the National Quality Requirements for sepsis set out in Annex A of the Service Conditions to align with this NICE guidance. Similarly, we have updated the metric definitions included in Appendix 2 of the Technical Guidance to align with this change.

Clarifications in response to feedback

The section below deals with areas where we think it is helpful for us to offer further clarification on proposed changes which have been retained in the final Contract.

C(E)TR – we were asked whether C(E)TRs could be included in the contract. We can confirm that these are already covered at Service Condition 6.17 as follows:

Care (Education) and Treatment Reviews 6.17 The Parties must co-operate with each other, with relevant local authorities, and with other relevant providers of health, social care, education and housing services, to implement and comply with Care (Education) and Treatment Review Guidance.	**MH, MHSS**

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