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2026/27 NHS Standard Contract

Technical Guidance

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Executive Summary

1 Introduction

1.1 The NHS Standard Contract is published by NHS England, and it is mandated for use by Integrated Care Boards (ICBs) and NHS England for all their clinical services contracts, with the exception of those for primary care services (unless these are commissioned by using Schedule 2L (Provisions Applicable for Primary Medical Services)).

1.2 The Contract continues to be published in both full-length and shorter-form versions. This guidance document is relevant to both forms of the Contract, and guidance on when the shorter-form version should be used is set out in paragraph 9 below.

2 The 2026/27 Contract

2.1 The updated Contract is intended to set national terms and conditions applicable for the 2026/27 financial year. As always, if urgent issues arise during 2026/27 which require any amendment to the Contract, NHS England will consult on material changes and publish revised terms and conditions.

2.2 Written, signed contracts must be put in place, for the full 2026/27 financial year, between commissioners and all providers (that is, with both Trusts and non-NHS providers). **Every effort must be made to agree and sign contracts as soon as possible.** It is especially important that, following an appropriate process under the NHS Provider Selection Regime and NHS England's patient choice guidance, ICBs promptly sign their proposed contracts with non-NHS providers of elective physical and mental health services. Prompt contract signature, by 1 April 2026, will ensure that such providers can continue, without any risk of interruption, to make elective capacity available to the NHS to support with efforts to reduce waiting times. The backstop for resolving any contract disputes between commissioners and Trusts and for contracts being signed is 22 April 2026.

2.3 Commissioners should collaborate with each other in their contractual arrangements with providers, with multiple commissioners often signing the same single contract with a large provider. A model Collaborative Commissioning Agreement is available on the NHS Standard Contract webpage to facilitate this.

2.4 For contracts where payment is to depend on activity volumes, opening activity plans and estimated annual financial values should be set at realistic levels. This is important for providers, because it means that the monthly cashflow they receive ('on-account payments') will be broadly in line with the expected profile of costs they will face.

2.5 In most instances, commissioners and providers will be signing new contracts for 2026/27. Where that is the case, the updated 2026/27 version of the Contract must be used – in its final post-consultation form.

2.6 Not all local contracts will expire on 31 March 2026, however. Where an existing contract (awarded prior to that date) continues into 2026/27:

- the updated General Conditions and Service Conditions, once published online by NHS England in final post-consultation form, will take automatic effect from 1 April 2026, without any need for local action; but
- the commissioner and provider may need to agree a Variation, locally between them, to update aspects of the Particulars (prices and contract values, for instance).

See paragraph 22 below for further detail.

2.7 The material changes to the Contract for 2026/27 are described in section 3 below.

3 Changes to Contract content for 2026/27

3.1 Material changes to the Contract for 2026/27 (whether to the full-length version, the shorter-form version or both) are set out below.

National Quality Requirements

National access and waiting times standards are set out as National Quality Requirements in Annex A of the Service Conditions. As is our usual practice, we have updated Annex A to reflect any specific changes to these standards set out in the Medium Term Planning Framework 2026/27 to 2028/29.

We have made changes to the Contract to require commissioners to include in the Local Quality Requirements (Schedule 4B (National Quality Requirements with Locally-agreed Thresholds) any targets agreed as part of the annual planning round which differ from targets as set out in the National Quality Requirements, and to make these the applicable targets for these metrics. This affects only a small number of targets as set out below.

Topic	Change	New Contract Reference
National Quality Requirements – Cancer and Urgent Care	In order to ensure alignment between Contract metrics and those set out in the Medium Term Planning Framework 2026/27 to 2028/29, we have updated the following metrics to align with the wording and targets of the metrics set out in the Framework: • % of service users waiting no more than 31 days from decision to treat to cancer treatment • % of service users waiting no more than 62 days from GP referral to first cancer treatment	Service Conditions – Annex A (FL and SF)

	• % of A+E attendances where the service user was admitted, transferred or discharged within 12 hours • Category 2 ambulance response times – mean time to arrive • % of ambulance handovers completed within 15 minutes	
National Quality Requirements – Talking Therapies	To align the Contract with the provider-level metrics included in the Medium Term Planning Framework 2026/27 to 2028/29, we have introduced the following two new National Quality Requirements: • Talking Therapies - percentage of adults and older adults receiving a course of treatment and achieving reliable recovery • Talking Therapies - percentage of adults and older adults receiving a course of treatment and achieving reliable improvement	Service Conditions Annex A (FL and SF)
National Quality Requirements with Locally-agreed Thresholds	There are a small number of metrics set out in the Medium Term Planning Framework 2026/27 to 2028/29, which require the agreement of local improvement targets with NHS England to work towards longer term achievement of the previous standards. In order to ensure alignment with the Contract, we will require commissioners to enter in the Locally-agreed Quality Requirements Schedule (Schedule 4B) the targets agreed with NHS England for the following metrics as part of the annual planning round: • % of service users waiting no longer than 18 weeks for treatment • DM01 - % of service users waiting less than 6 weeks from referral for a diagnostic test • % of A+E attendances where the service user was not admitted, transferred or discharged within 12 hours • Category 2 ambulance response times – mean time to arrive • % of ambulance handovers completed within 15 minutes In general, drafting in the Particulars cannot override the provisions of the Service Conditions. However, to allow these targets to take effect, we have added a note to Annex A (National Quality Requirements) of the Service Conditions to give effect to the targets set out in Schedule 4B (Locally-agreed Quality Requirements). We have also clarified at SC3.1.1 that the National Quality Requirements may be amended in the Local Quality Requirements, where a different target has been agreed with NHS England during the annual planning round.	Service Conditions – Annex A, 3.1.1 (FL) and 3.1 (SF) Particulars – Schedules 4A and 4B

Additions and Updates to Reflect National Priorities and Guidance

3.2 This section sets out:

- a small number of new additions and updates to the Contract which are aimed at promoting improvements in how services are delivered for patients, in line with the latest national policy direction, and

- changes which we have made to update existing Contract requirements to keep the Contract consistent with published national standards and policies.

Topic	**Change**	**New Contract Reference**
Equality Act 2010	The Equality Act has been strengthened with further additions including section 40A which creates a proactive preventive duty on sexual harassment. We therefore have made an addition of a reference to this section to the Provider's obligations in relation to the Equality Act at SC13.3.	Service Conditions – 13.3 (FL only)
Health Inequalities Action Plan	We provide a separate schedule in the Particulars – Schedule 2N – for the inclusion of a Health Inequalities Action Plan that sets out commissioner and provider actions to address Health Inequalities. We have made additions to the guidance included in the particulars of links to related information sources which might support construction of the plan and of further guidance on language access. The schedule remains optional but we strongly recommend commissioners and providers to use it where possible and to monitor achievement of plans to support action on health inequalities in their system.	Particulars – Schedule 2N (FL only)
Martha's Rule	In 2024/25, NHS England completed a pilot at 143 sites of the implementation of Martha's Rule. Martha's Rule is a patient safety initiative developed following the death of Martha Mills, and other cases related to management of deterioration, to support the early detection of patient deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon. Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that their or their loved one's condition is getting worse and their concerns are not being responded to. Early evidence from the pilot suggested that the implementation of Martha's Rule in pilot sites has saved lives and therefore we have added to the Contract a requirement for NHS Trusts and Foundation Trusts to implement the three core components of Martha's Rule by 31 March 2027 - see NHS England » Martha's Rule.	Service Conditions – 33.13 (FL only) General Conditions – Definitions (FL only)
System Collaboration	We have included in the Contract for some time, requirements for the Parties to collaborate on a Joint System Plan and Integrated Care Strategy. As these	Service Conditions

	terms are no longer in use and in 2026/27 there will be a return to financial planning at an organisation rather than system level, we have amended this requirement to require the parties to collaborate in the achievement of financial balance, without destabilising the financial position of any other organisation.	– 4.7 (FL only)
Outlier Management	NHS England is currently working on a new Outlier management process which is likely to be implemented for 2026/27 and reported nationally. We have therefore added a requirement to SC26 Clinical Networks, National Audit Programmes and Approved Research Studies requiring providers to engage in national outlier management processes as set out in the HQIP-NCAPOP Outlier Guidance.	Service Condition 26.1.4 (FL only)
Antimicrobial Usage	Following the publication last year of the updated National Action Plan for Antimicrobial Resistance, there has been a change in targets under the plan to focus on reducing the overall consumption of antibiotics and increasing the proportion of antibiotic consumption comprised of the World Health Organisation (WHO) Access Category of antibiotics. We have therefore reworded the requirement under SC21.3 to reflect these changes and added a definition for the WHO Access Category, details of which can be found at: UK Access, Watch, Reserve, and Other classification for antibiotics (UK-AWaRe antibiotic classification) - GOV.UK	Service Conditions – 21.3 (FL only) General Conditions – Definitions (FL only)
Contract Management	It has been suggested on a number of occasions in our annual Contract consultations that the provisions for Contract Management at GC9 are overly long and complex, especially since we have removed the separate provisions on management of information breaches. We have therefore taken the opportunity this year to make some changes which would simplify the application of the conditions as follows: • To make clear what actions can be taken by a party if the other party does not engage with the process of setting a meeting • To align the penalties for failure to engage with the penalties for remedy of a breach in order to remove any perverse financial incentive for non-engagement • To reduce the timeframe for the process by allowing a Joint Investigation to be agreed and begun at the first meeting • To remove the requirement to provide Exception Reports and instead clarify that the intended content of Exception Reports can be included in the Remedial Action Plan and therefore to remove Exception Report from GC17 and the definition of Suspension Event.	General Conditions – 9, (FL and SF) 17.10.7 (FL only) and Definitions (FL and SF)

Service Development and Improvement Plans (SDIPs) and Data Quality and Improvement Plan (DQIP)

3.3 This section sets out changes made to Service Development and Improvement Plans and Data Quality Improvement Plans. Full details of these SDIPs are set out at section 43.5 of this guidance and details of the DQIP are at section 43.10.

Topic	Change	New Contract Reference
UK Standard for Microbiology Investigations	There is currently variation in service delivery and outcomes for blood culture pathway across the NHS in England and this SDIP for acute providers aims to improve patient outcomes and Anti-Microbial Stewardship benefits and deliver the expectations of the Five-year National Action Plan for AMR 2024-29. The SDIP should set out the steps that providers will take to ensure full and ongoing compliance with the UK Standard for Microbiology Investigations Syndromic 12 by no later than 31 March 2027.	Particulars – Schedule 6C (FL only)
C. difficile infection ascertainment	Compliance with the national guidance on diarrhoea sampling and CDI testing is currently variable across acute Trusts. This SDIP has been developed to support improvement in compliance with the UK Standard for Microbiology Investigations – Investigation of faecal specimens for Clostridioides difficile. SDIPs should set targets for each acute provider to achieve compliance with the national guidance requirements by 31 March 2027. • The previous 3 SDIPs on Paediatric Hearing Services, Staff Training in Asthma Care and the Autism Assessment Pathway have now been removed but can obviously still be deployed locally if there are outstanding actions.	Particulars – Schedule 6C (FL only)
Data Quality Improvement Plan (DQIP)	As timely, high quality data for NHS services is a critical focus of the 10 Year Health Plan, this year we have added to the Contract a requirement for providers to have no more than 5% variance in activity recorded and coded at first (flex) and final (freeze) reconciliation dates. As not all providers are currently compliant with those requirements, we also require commissioners to agree a DQIP for providers who are not compliant with the Service Condition. Commissioners are required to review the current variation between flex and freeze data at their providers, compared to the required targets. Where providers are not meeting the targets set out in the Service Conditions, commissioners and providers should then draft a DQIP for inclusion in their contract, setting out the steps that providers will take to work towards meeting those targets by the end of 2026/27.	Service Conditions 28.18 (FL only) Particulars – Schedule 6B (FL only)

Safeguarding

3.4 This section sets out changes made relating to provisions in the Contract dealing with safeguarding.

Topic	Change	New Contract Reference
Violence Prevention and Reduction Standard	To support the implementation of the non-pay commitments agreed between the government and the NHS Staff Council in May 2023, NHS Staff Council joint statement on 2023 non-pay commitments | NHS Employers, and to reinforce a system-wide commitment to violence prevention and staff safety, we have made a change to the requirement to use all reasonable endeavours to implement the Violence Prevention and Reduction Standard. This makes it mandatory to implement the Standard for all NHS Trusts and Foundation Trusts to ensure consistency across NHS providers as part of the phased delivery plan over the next two years.	General Conditions – 5.9.2 (FL only)
Safeguarding Children and Adults	We have reviewed the provisions of SC32 on Safeguarding Children and Adults and made the following changes: • Added SC32.1.3 to require providers to proactively take steps to prevent abuse by responding early to risk factors or indications of abuse or neglect. This is intended to ensure that providers do not simply report signs of abuse but take steps to ensure that they can identify early warning signs and indicators • Removed the reference to the Care Act regulations at SC32.3 as this is covered by the reference to the Act itself • Added a requirement to include domestic abuse in safeguarding programmes at SC32.5.	Service Conditions – 32.1 (FL and SF), 32.3 (FL only), 32.5 (FL and SF)
Mental Capacity Act – Learning Disability	We have added to the contract 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. In particular, NHS England requires providers to use the forms included within the guidance to help capture capacity assessment and best interest assessments. This is guidance that NHS England has produced and published about the implementation of the MCA for providers of acute care and follows on from the HSSIB investigation into the care of people with a learning disability in acute settings. The forms will assist staff in providers to comply with the MCA following the lessons on record-keeping and decision-making identified in cases such as AMDC v AG & Anor [2020] EWCOP 58.	Service Condition 32.3.3 and Definitions (FL only)

Green NHS

3.5 This section sets out changes made aimed at updating the Contract to take account of guidance and policy changes in procurement, energy and estates matters.

Topic	Change	New Contract Reference
Nitrous Oxide Toolkit	NHS England has published a Nitrous Oxide Toolkit together with UCL Partners to help NHS trusts reduce waste from VA-piped nitrous oxide and nitrous oxide/oxygen mixture gas delivery systems. As the Nitrous Oxide Toolkit covers some items previously set out separately in the Contract, we have made an amendment to the Green NHS provisions to reference the toolkit.	Service Conditions – 18.3.2.3 (FL only)
Capital Investment	To ensure the effective use of capital investment in decarbonisation projects, we have added a new requirement for NHS Trusts and Foundation Trusts to deliver the allocated capital investment and develop business cases where appropriate.	Service Conditions – 18.5.3 (FL only)

NHS Payment Scheme 2026/27

3.6 This section sets out amendments aimed at updating the Contract to take account of guidance and policy changes in procurement, energy and estates matters.

Topic	Change	New Contract Reference
Aligned Payment and Incentive Changes	The 2026/27 NHS Payment Scheme proposed some changes to the way that Urgent Care and Radiotherapy are funded which will alter the composition of the fixed payment and also requires some adjustments to the fixed payment following work on deconstructing block payments. As, at the time of publication of the final Contract, the Payment Scheme had not been published a reference has been added to Schedule 3A explaining to commissioners that it should be populated in accordance with the guidance published in the 2026/27 Payment Scheme.	Particulars – Schedule 3A and 3D (FL only)

Activity Management Provisions

3.7 For the 2025/26 Contract, we made a number of amendments to support commissioners in the management of activity funded on a variable basis. As these provisions were new for commissioners, we also introduced an escalation process to support providers who felt that commissioners were not following our Technical Guidance when applying their new powers.

In response to feedback about the practical application of the new IAP and AMP setting processes, we made some amendments to the Contract to clarify or simplify these processes.

Topic	Change	New Contract Reference
Indicative Activity Plans	To take account of the earlier publication of this year's Contract and the impact on Indicative Activity Plan setting, we made the following change: • as we published the final Contract in January 2026, we have amended the dates on which a commissioner can set an Indicative Activity Plan to align with the Service Commencement Date of each contract, usually 1 April 2026.	Service Conditions - 29.5, 29.5A, 29.6 (FL) and 29.3A (SF)
Activity Management Processes	Following feedback on the length of time it takes to complete Activity Management processes, we have shortened the timeframe for commissioners to set an Activity Management Plan when one has not been agreed and also clarified the position if the provider does not engage with the process.	Service Conditions 29.14 (FL) and 29.7B (SF)
Escalation Procedure	In order to ensure that Commissioners continue to act reasonably and to follow our guidance in the setting of plans, we made adherence to that guidance a mandatory obligation under the Contract and included new terms to that effect and redrafted the Technical Guidance accordingly. Some additions have been made to the Technical Guidance to clarify the criteria and circumstances when an escalation can be made.	Service Conditions 29.5B and 29.14A (FL) and 29.3C and 29.7C (SF)

Other Smaller Updates

3.8 Other smaller updates have been made to the Contract to ensure that the Contract wording remains current, accurate and robust.

Topic	Change	New Contract Reference
DAPB4042 Discharge Standard	Information Standard DAPB4042 Transfer of Care – Acute Inpatient Discharge Information Standard has been deprecated which means that the standard has fallen out of its period of assurance. We have therefore made a minor amendment to the Definitions to clarify that, whilst Trusts may choose to continue to follow this Standard, it is no longer mandatory unless uplifted before the 12-month deprecation period expires. We have also updated the publication link as these Standards will now be published by NHS England at https://standards.nhs.uk/. We anticipate that a full review of	General Conditions – Definitions (FL only)

	the Discharge Standards may be undertaken before the 27/28 Contract is published.	
Compliant Ambulance Vehicle Supply Contract	We have procured two new frameworks for base vehicle supply and ambulance conversions. The definition of Compliant Ambulance Vehicle Supply Contract has therefore been updated to include details of these two new frameworks.	General Conditions – Definitions (FL only)
Shorter-form Contract	To improve ease of use, we have taken the decision to include Schedule 6E within the Shorter-form Contract rather than publish it as a separate schedule. The content of the Schedule is unchanged.	Particulars Schedule 6E (SF)
Core Skills Training Framework	The Core Skills Training Framework is likely to be replaced later this year with the NHS Competencies for All Framework. As this Framework is not yet published, we have amended the definition for the Core Skills Training Framework to make clear that it covers any successor framework.	General Conditions – Definitions (FL and SF)
Improving the Working Lives of Resident Doctors	We have published a new 10-point plan on resident doctors and have therefore removed the reference to 'Improving Working Lives of Resident Doctors' and replaced it with 'Getting the Basics Right for Resident Doctors: 10 Point Plan' published by NHS England at: https://www.england.nhs.uk/publication/getting-the-basics-right-for-resident-doctors-10-point-plan/.	General Conditions – 5.9.3.4 and Definitions (FL only)
EDI Improvement Plans	We have made a small addition to the requirement for providers to implement the high impact actions set out in the NHS Equality, Diversity and Inclusion Improvement Plan to clarify that the Provider may be required to report also on any locally agreed action plans related to workforce EDI.	Service Conditions – 13.6 (FL only)
Formulary	Following feedback received in last year's consultation, we have reviewed the Formulary provisions and extended these to include Ambulance providers as they are also able to prescribe and required to maintain a formulary.	Service Conditions – 27.1 (FL only)
National Guardian's Office	It was announced in 2025 that the National Guardian's Office would close in 2026. NHS England will then take over the responsibility for national support and guidance of Freedom to Speak Up Guardians and the role will remain a requirement in the NHS Standard Contract for 2026/27. We have made some minor adjustments to the General Conditions and Definitions to acknowledge this change while recognising that for the time being guidance will still be published on the National Guardian's Office website until full successor arrangements are completed.	General Conditions – 5.10.2-3 (FL) and 5.7.2-3 (SF) Definitions (FL and SF)
Mental Health Crisis Care Concordat	The Crisis Care Concordat website has now been decommissioned by the Department of Health and Social Care. We have changed the requirement at Service Condition 15.1 ('to have regard to the Concordat') to instead require the Parties to work together and with other providers, police and local authorities to support those in mental health crisis and to identify Places of Safety. We have therefore also	Service Conditions – 15.1 General Conditions – Definitions (FL and SF)

	removed the definition for the Mental Health Crisis Care Concordat.	

Other minor changes have been made to rationalise and improve the Contract where we have considered it appropriate to do so.

4 Advice and support

Queries and updates

4.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact england.contractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general.

4.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.

4.3 Our team runs periodic webinars on different contracting topics, and these provide a useful introduction to many of the issues covered in this Guidance. Slides and recordings from our webinars are available on our page on the FutureNHS platform. Please see paragraph 30 below for more information.

Model grant agreement and model sub-contract

4.4 NHS England has also developed a model grant agreement as a funding vehicle for voluntary bodies, for commissioners to use where a commissioning contract may not be appropriate. The model agreement and associated guidance are available on the NHS Grant agreement web page. See also paragraph 11 below.

4.5 Model sub-contracts suitable for use with the full-length Contract and with the shorter-form Contract will be published on the NHS Standard Contract 2026/27webpage in due course. See also paragraph 38 below.

Model System Collaboration and Financial Management Agreement

4.6 For some years, we have published a model System collaboration and financial management agreement (SCFMA). This is a framework document which an ICB and its local partner Trusts can choose to use locally, to set out how they will work together to manage NHS system finances and in-year financial risks.

4.7 We recognise that alternative governance arrangements will often now have been put in place at local level (ICB sub-committees, for example, or joint committees with Trusts) through which the aspirations set out in the model SCFMA can be delivered. Use of the SCFMA is therefore not mandatory, but we are continuing to publish it, on the NHS Standard Contract 2026/27 webpage, for use where local systems wish to adopt it, or to draw on it for their own locally-developed arrangements.

Section A General guidance on contracting

5 Terminology

5.1 Throughout this guidance, we continue to use the generic term "the NHS Standard Contract" or "the Contract" to refer collectively to both the full-length and shorter-form versions. Where there are material differences in approach between the two versions of the Contract, we identify these below.

5.2 Obligations under the Contract are expressed in different ways. We are sometimes asked to explain what expressions such as "use reasonable endeavours to" or "have regard to" mean, in practical terms. We have set out a brief guide to the commonly used terms below.

If the Contract says that the relevant party **must** do something (for example, "must comply", "must submit", "must implement"), it means that that party has an absolute obligation to do that something, regardless of the cost or inconvenience to them it entails – no excuses (but see below).

But many obligations are expressed in other ways. As a general rule of thumb:

If the Contract says that the relevant party **must use all reasonable endeavours** to do something, it means that that party must pursue every reasonable course of action open to it to achieve the required objective. It can't simply try one course of action and, if that doesn't work, give up. But it isn't an absolute obligation: it doesn't mean that the relevant party has to spend unlimited or disproportionate sums of money or other resources in pursuing the relevant objective, but rather what is reasonable in the circumstances.

If the Contract says that the relevant party **must use reasonable endeavours** to do something, that's a slightly lesser obligation. It means that that party must pursue a reasonable course of action open to it to achieve the required objective, but it doesn't necessarily have to pursue lots of different courses of action. Again, it isn't an absolute obligation: it doesn't mean that the relevant party has to spend unlimited or disproportionate sums of money or other resources in pursuing the relevant objective, but rather what is reasonable in the circumstances.

If the Contract says that a party **must have regard to** something (usually Guidance) it means that the party must make sure that it is aware of what that Guidance says and takes account of it in its decisions and actions. The party should assume that it would need to have a good reason to justify departing from that Guidance.

Note that, however the obligation is expressed, a party may be entitled to relief from liability under the Contract for any failure to comply with it, if that failure is caused by matters beyond the reasonable control of that party: see GC28 and the definition of Event of Force Majeure.

6 Content of this section

6.1 This section of the Technical Guidance offers broad advice about general contracting issues.

- Paragraphs 7-14 deal with the NHS Standard Contract itself – when it should be used, its legal status, the elements which are for local completion, who can be party to it, and the distinction between the full-length and shorter-form versions. They also address collaborative contracting arrangements and alternatives to contracts such as grant agreements.

- Paragraphs 15-20 cover provider selection and the award of contracts. They describe the communications which will be needed in advance of contract expiry and explain what is possible in terms of contract duration and extension.

- Paragraphs 21-25 deal with contract signature, set out what happens when a contract is not signed and describe the arrangements for dispute resolution and Non-Contract Activity.

- Paragraphs 26-28 describe potential models for contracting for integrated services and for personalised care and offer brief advice on using the Contract to operate call-off arrangements under frameworks. Paragraph 30 provides links to national helpdesks which can offer advice on contract-related issues.

6.2 We have provided, at Appendix 3, some example scenarios illustrating which form of contract, sub-contract or other agreement should be used in different scenarios.

7 When should the NHS Standard Contract be used?

7.1 The NHS Standard Contract exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of provider and allowing economies in the drafting and production of contracts, for example in respect of legal advice. It also allows NHS England, by inclusion of specific requirements on local bodies, to promote implementation at local level of key national clinical and service priorities.

7.2 By its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended), NHS England mandates that the NHS Standard Contract **must** be used by ICBs and by NHS England when commissioning NHS-funded healthcare services. This mandate continues to apply, **and must by law be complied with**, notwithstanding the establishment of ICBs and the general move towards system working and system accountability. Commissioners and providers **must not** draft their own local alternative form of contract (or service level agreement or memorandum of understanding) for delivery of a healthcare service.

7.3 In determining what are 'healthcare services', a useful point of reference will be whether registration with the Care Quality Commission (CQC) is required in order for an organisation to be permitted to provide them. The CQC publishes scope of registration guidance on this. "Healthcare services" include acute, ambulance,

continuing healthcare, community-based, high-secure, mental health and learning disability services. Another helpful point of reference is the scope of the NHS Provider Selection Regime (PSR) (see paragraph 15 below). The PSR statutory guidance provides, at Annex A, a list of "common procurement vocabulary" codes for healthcare services within scope of the PSR. Where an NHS commissioner is commissioning any healthcare service within scope of the PSR from a provider, then either the NHS Standard Contract or (where applicable) the relevant form of primary care contract must be used.

7.4 Note that the CQC's guidance includes a specific section on transport services, which makes clear that registration is required only for "transport (ambulance) services for the primary purpose of carrying a person who requires treatment". Where a package of services being commissioned includes transport services **within** scope of CQC registration, therefore, the NHS Standard Contract must be used. By contrast, a package of transport services **outside** the scope of registration should not be commissioned using the NHS Standard Contract.

7.5 The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.

7.6 The only exceptions relate to primary care services. As a general rule, for primary care services commissioned by NHS England (or by ICBs under delegated authority), the relevant primary care contract must be used, not the NHS Standard Contract. More specific detail is as follows.

- **General practice.** Guidance published by NHS England clarifies that, where ICBs wish to commission local enhanced services from general practices, they can now do so either by using the GP contract as the contracting vehicle or by using the NHS Standard Contract.

- **Community pharmacies and optometrists.** ICBs must use the NHS Standard Contract to commission any community-based services to be provided by pharmacies and optometrists which are beyond the scope of services covered by the Community Pharmacy Contractual Framework, or primary ophthalmic services contracts, as appropriate. Note however that, under the delegated arrangements for community pharmacies in place from April 2023, ICBs may choose to commission any of the enhanced services listed in Part 4 of the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 either using their own local documentation under the Community Pharmacy Contractual Framework or by using an NHS Standard Contract. Advanced services listed in the Directions should not be commissioned using the NHS Standard Contract.

- **Multi-neighbourhood providers**. We expect to develop a new schedule for use with the NHS Standard Contract in the commissioning of multi-neighbourhood services as described in the 10 Year Health Plan for England. This is likely to be published for consultation later during 2025/26 for use in 2026/27.

7.7 The NHS Standard Contract must not be used by provider organisations when contracting with other provider organisations for the provision of clinical services. It is not designed for that purpose and is not fit for that purpose. In most circumstances, such arrangements will be correctly categorised as a sub-contracting of services commissioned under an NHS Standard Contract – see paragraph 38 below.

8 Legally binding agreements

8.1 The Contract creates legally binding agreements between NHS commissioners and Foundation Trust, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract documentation, and their contracts should be treated by NHS commissioners with the same degree of rigour and seriousness as if they were legally binding. Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding between those parties.

9 When to use the shorter-form Contract

9.1 The shorter-form Contract **must not be used** for contracts under which acute, cancer, NHS111, A+E, Urgent Treatment Centres or emergency ambulance services, or any other hospital inpatient services, including for mental health and learning disabilities, are being commissioned.

9.2 Restricting use of the shorter-form Contract in this way significantly reduces the number of detailed requirements which it has to include, and these providers (that is, providers of those services for which the shorter-form Contract must not be used) tend to be larger organisations.

9.3 Commissioners **may** use the shorter-form Contract for all other services for which the NHS Standard Contract is mandated – 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.

9.4 The shorter-form version of the Contract must not be used where the Aligned Payment and Incentive (API) rules under the NHS Payment Scheme apply. Given that the API rules now apply to virtually all contracts with Trusts, this now means in practice that the shorter-form version of the Contract should generally not be used for Trusts, only for non-NHS providers. However, the 2023/25 NHS Payment Scheme created a new exception to the API rules, covering a situation where "the service provided is a single non-acute service procured by an ICB from an NHS provider". This will allow some flexibility for commissioners to award shorter-form Contracts, on the basis of locally agreed prices, to Trusts as well as to non-NHS providers. This may be appropriate for instance, where an ICB wishes to arrange a small community-based service on an "any qualified provider" basis.

9.5 Within the parameters set out in this Guidance, it is for commissioners to determine when they wish to use the shorter-form version of the Contract, as opposed to the longer form.

9.6 We have not set a specific financial threshold for use of the shorter-form contract, but we **strongly encourage** commissioners to use it for appropriate services (as described in 9.3 above) with lower annual values, which will tend to include the great majority of contracts held by the smaller provider organisations which this contract form is particularly intended to assist. The end result of this approach should be that the shorter-form Contract is used for most contracts with smaller providers, including voluntary organisations, hospices (if grant agreements are not being used – see paragraph 11 below), care home operators and providers of enhanced services such as general practices, pharmacies and optometrists.

9.7 However, in deciding whether to use the shorter-form Contract to commission services for which it may be used, commissioners should consider carefully the differences in the management process and other provisions between the shorter-form and full-length Contracts. If the "lighter touch" approach of the shorter-form is not thought appropriate to the services, the relationship or the circumstances, the full-length Contract may be used. Also, if the provider is providing other services under the full-length Contract, it may be more appropriate to keep all services on this form.

10 What elements of the Contract can be agreed locally

10.1 The elements of the Contract for local agreement fall within the Particulars. The Service Conditions may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The General Conditions must not be varied at all.

10.2 Commissioners must not:

- put in place locally designed contracts or service level agreements for healthcare services, instead of the NHS Standard Contract; or
- vary any provision of the NHS Standard Contract except as permitted by GC13 (Variations); or
- seek to override any aspect of the NHS Standard Contract.

10.3 Where commissioners and providers wish to record agreements they have reached on additional matters, they may use Schedule 2G (Other Local Agreements, Policies and Procedures) or (in the full-length Contract) Schedule 5A (Documents Relied On) for this purpose. Commissioners are reminded that any such local agreements must not conflict with the national terms of the Contract. In the event of any such conflict or inconsistency, the national terms of the Contract will apply. GC1 makes clear that provisions in the General and Service Conditions will take precedence over the content of the Particulars – so any attempt to override the national terms will be ineffective.

11 Use of grant agreements

11.1 Where voluntary sector organisations provide healthcare services, or other services in support of the healthcare needs of the local community, commissioners may choose to provide funding support for those services through grant agreements, rather than using the NHS Standard Contract.

11.2 Use of the Standard Contract is, however, necessary where it is clear that the commissioner is commissioning (as distinct from providing funding support for) a specific clinical service (as distinct from non-clinical or clinical support services) from a voluntary sector organisation. (Note also that, whatever the nature of the services being provided, if those services are being competitively tendered and potential providers include both voluntary sector and other types of provider, the same form of contract must be offered to all potential providers of the relevant service – which precludes the use of a grant agreement.)

11.3 However, where the commissioner is providing funding support towards the costs a voluntary sector provider faces in running a service (and especially where some of the providers' costs are being met by donations and/or payments by service users), it will generally be more appropriate for commissioners to use a grant agreement rather than the Standard Contract, and we would strongly urge them to do so. This will apply to some hospice services, for example.

11.4 NHS England has published a non-mandatory model grant agreement for use by ICBs with voluntary sector organisations which provide clinical services (available on the NHS Grant Agreement web page). This has been designed to provide an appropriate level of assurance for commissioners about the quality of care to be provided by the voluntary organisation – but without replicating the more onerous requirements of a full contract. Additional guidance on grant funding is available on the NHS Grant Agreement web page.

11.5 Where commissioners choose not to use the national model grant agreement, they should ensure that any locally drafted grant agreements are very clear as to the purpose for which the grant is being made, suitably robust (particularly in terms of clinical governance requirements) and properly managed.

12 NHS Continuing Health Care and Funded Nursing Care

12.1 The NHS Standard Contract (typically the shorter-form version) must be used where an NHS commissioner is funding an individual's NHS Continuing Health Care (NHS CHC) placement in a care home or package of home care. Commissioners must not rely on locally drafted alternatives to the NHS Standard Contract or on purchase orders alone. Nor are Non-Contract Activity approaches suitable in a CHC context. CHC is, typically, planned activity, meaning that there should be time to put appropriate contract documentation in place; and the interests of service users and commissioners will be best served if this is always done.

12.2 It is clear that there will often be benefits from collaborative commissioning of, and contracting for, NHS CHC services – producing economies of scale for commissioners and reducing the number of separate contracts a care home needs

to hold, for instance. Collaborative contracting will also enable commissioners to work jointly in respect of quality oversight of NHS CHC services, ensuring that their limited resource is used effectively and without placing multiple burdens on providers.

12.3 When contracting for NHS CHC, commissioners may put in place standardised care packages with fixed prices for different levels of complexity of need, and these should be set out in Schedule 3C (Local Prices). Where individually priced packages of care for new patients are likely to be agreed in-year based on differing inputs from different staff types, Schedule 3C can also record the agreed unit prices for such inputs. It should be possible to avoid having to vary the contract formally in-year to record each new or revised individual care package. The call-off / framework arrangements described in section 27 below will often work well for CHC, allowing the detailed requirements for an individual service user to be set out in a specific Individual Placement Agreement, which sits within an over-arching contract with the provider.

12.4 We do not mandate use of the NHS Standard Contract in respect of NHS Funded Nursing Care (NHS FNC) (where the NHS makes a nationally set contribution to the costs of a nursing home resident's nursing care). If commissioners and providers agree locally that use of the Contract offers an effective route through which NHS FNC payments can be administered, they may use it.

12.5 Further information is available on CHC in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and on FNC in NHS-funded Nursing Care Practice Guidance.

12.6 DHSC has published Hospital Discharge and Community Support Guidance, which came into effect on 1 April 2022. It states that local areas should adopt discharge processes that best meet the needs of the local population. In situations where short-term residential care placements are to be provided in order for requirements for longer-term care to be properly assessed, and where these placements are to be funded in whole or in part by the NHS, they should be commissioned using the NHS Standard Contract.

13 Collaborative contracting

13.1 The NHS Standard Contract may be used for both bilateral and multilateral commissioning i.e. for commissioning by a single commissioner or by a group of commissioners collaborating to commission together, with one acting as the co-ordinating commissioner.

13.2 Clearly, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model – but it is an approach which we strongly encourage. There can be great benefits for commissioners from working closely together to negotiate and manage contracts with providers. Using the co-ordinating commissioner model enables a consistent approach to contracting and is more efficient for both commissioners and providers, avoiding a proliferation of small, separate contracts. Collaborative commissioning between ICBs remains an important tool and the Provider Selection Regime is not a barrier to collaborative commissioning.

13.3 The “footprint” for collaborative arrangements is for local agreement – but it makes sense for it to be as wide as possible, ideally including all of the commissioners who will need to have a written, signed contract with that provider, rather than falling within the new Low Volume Activity arrangements for Trusts or traditional Non-Contract Activity arrangements for other providers (see paragraph 25 below).

13.4 In particular, we would encourage commissioners to work together to use, where they can, consistent contract metrics for the same provider – local quality and reporting requirements, local agreements, policies and procedures, Activity Planning Assumptions or Prior Approval Schemes. This will help to reduce the administrative burden which providers face.

13.5 Where commissioners choose to contract collaboratively, they should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider, and how they are to make decisions in relation to the contract and the provider selection process to be adopted in relation to it and instruct the co-ordinating commissioner to act on their behalf, in a formal collaborative commissioning agreement (CCA). The CCA is a separate document entered into by a group of commissioners and governs the way the commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, a contract which has been signed by all the parties (as outlined in paragraph 21 below) is still legally effective and binding on all the parties without a collaborative agreement in place. The CCA should not be included in the contract (though the allocation of roles and responsibilities between commissioners which are party to a contract can, where necessary, be set out in Schedule 5C (Commissioner Roles and Responsibilities) to that contract).

13.6 Model CCAs are available here: Collaborative Commissioning Agreements.

13.7 One specific addition to the model CCAs should be highlighted. Certain management actions under the Contract fall to the co-ordinating commissioner to take, rather than to each individual commissioner; these are known as “Co-ordinating Commissioner Actions”. It is important that each individual commissioner has confidence that the co-ordinating commissioner will take appropriate action on its behalf. In general, this should not be an issue – multiple ICBs commissioning the same services from a provider will all have the same interest in seeing performance issues with those services addressed, for example. But there may be instances (for instance in a joint contract signed between NHS England and ICBs) where an individual commissioner wants the co-ordinating commissioner to take action **in respect of a service or population for which only that commissioner has responsibility**. We have therefore added provisions to the model CCA at paragraph 7, making clear that, in the circumstances described above:

- a commissioner may request that the co-ordinating commissioner undertake a specific Co-ordinating Commissioner Action; and

- the co-ordinating commissioner must not unreasonably refuse to take such action.

13.8 Where NHS England is the sole commissioner party to a contract, but the lead role for commissioning of particular services from the provider is being taken by different NHS England teams, use of a formal CCA is not appropriate – as NHS England is one legal entity. However, it is important to ensure that the different teams understand what role each will play in managing the contract and communicate this clearly to the provider.

14 Which commissioners and providers can be party to the Contract

14.1 The Standard Contract **must** be used by ICBs and by NHS England in the circumstances explained in paragraph 7 above and **may** be used by local authorities and by other public bodies such as the police when commissioning healthcare services. Any combination of these commissioners may agree to work together to hold a single contract with a given provider, identifying a co-ordinating commissioner and putting in place a collaborative agreement as set out above.

14.2 Even where they are placing separate contracts from NHS commissioners, local authorities may wish to use the NHS Standard Contract, for example to commission services from a provider whose main business is the supply of services to NHS commissioners. In this situation, it is not mandatory for local authorities to use the NHS Standard Contract, but they may choose to do so. In a situation where NHS commissioners and a local authority are intending to sign the same single contract with a provider, however, and where the service being commissioned involves a healthcare service, then the NHS Standard Contract must be used. Additional requirements relating specifically to social care services can of course be included in the Schedules as appropriate, so long as they do not contradict the General Conditions or Service Conditions.

14.3 By contrast, where an NHS commissioner has delegated commissioning responsibility to a local authority under a formal lead commissioning (section 75) arrangement, the local authority would (in the absence of any agreement with the NHS commissioner to the contrary) be able to contract on its own chosen basis. As the NHS commissioner would not be a party to the contract, there would be no statutory requirement for the NHS Standard Contract to be used – although, again, the local authority may choose to do so. The NHS commissioner will however remain liable under statute for the performance of the functions it has delegated, so should satisfy itself that the arrangements being put in place are such that it can meet its statutory obligations.

14.4 Careful consideration needs to be given to s75 arrangements which will encompass services within scope of the NHS legal right of choice of provider. Where this is to be the case, in order to maintain patients' rights to choice, the NHS Standard Contract must always be used and the NHS commissioner must always be a direct signatory to the contract with the provider.

14.5 Note that s71 of the Health and Care Act 2022 inserted a new provision into the National Health Service Act 2006 (section 65Z5) to permit, amongst other things, NHS England or an ICB to arrange for any of its statutory functions to be exercised

by or jointly with an NHS Trust or NHS Foundation Trust. Using this power, an ICB could, in principle, delegate to a partner Trust the function of commissioning certain healthcare services on the ICB's behalf. The Trust would then be able to award NHS Standard Contracts to other providers, acting as commissioner under an NHS Standard Contract in relation to those services. But, for the time being, there is a national "hold" on delegation of these commissioning functions to Trusts – see annex G of Arrangements for delegation and joint exercise of statutory functions. Should this "hold" be lifted or relaxed in future, further detailed guidance will be published (including where necessary amendments to this Contract Technical Guidance) to explain the implications.

14.6 There is no restriction on the types of provider organisation which can hold an NHS Standard Contract. These can include (but are not limited to) NHS Trusts, NHS Foundation Trusts, charities and private companies of different types.

14.7 We are sometimes asked about whether a sole trader can be a provider under an NHS Standard Contract. There is no prohibition on awarding a commissioning contract to a sole trader, but the commissioner will need to satisfy itself (as it would in respect of any other type of provider) that the sole trader:

- is appropriately skilled, qualified and experienced to deliver the service in question; and
- holds a provider licence where required (and the facilities from which it intends to deliver the service are CQC registered); and
- has appropriate insurance or other indemnity arrangements in place; and
- has sufficient financial assets (and/or can provide an appropriate third-party guarantee or other form of security) to provide assurance to the ICB that he or she has the wherewithal to deliver the contract in accordance with its terms.

14.8 Some non-NHS providers have complex structures involving parent companies and subsidiaries / group companies. Commissioners must ensure that the contract they sign states the correct legal entity as the provider. This will be established through the process through which the provider is selected and the contract is awarded. The organisation selected through that process will be the provider named in the contract awarded and the contract must be signed by an authorised signatory of that organisation.

14.9 Providers may wish to operate an arrangement whereby the contract is held in the name of a parent company, but the services are in practice delivered by a subsidiary or other group company. In that case, the requirements of GC12 in relation to sub-contracting must be followed – with the provider requesting approval from the commissioner for the proposed sub-contracting arrangement and then, if that proposal is approved, putting in place a sub-contract between the provider company and the subsidiary / group company.

15 NHS Provider Selection Regime (PSR)

15.1 The NHS Provider Selection Regime came into effect on 1 January 2024 and is relevant to procurement processes which commenced after this date. The regime is established by the Health Care Services (Provider Selection Regime) Regulations 2023 (which we refer to from now on as the PSR Regulations). The PSR is a regime for the procurement of healthcare services by relevant authorities (NHS England, ICBs, NHS Trusts and NHS Foundation Trusts, and local and combined authorities).

15.2 Various resources to help relevant authorities and providers apply the regime are available on, or signposted from, the NHS England PSR webpage. These include PSR Statutory Guidance, a toolkit, a set of FAQs and a series of supporting webinars.

15.3 Where a competitive process is to be undertaken under the PSR, for healthcare services for which the NHS Standard Contract must be used, the same version of the Contract must be offered to all potential providers, regardless of type. This means that the commissioner must make clear, at the outset, whether its intention is to offer the full-length or shorter-form version of the Contract – and then act accordingly in terms of the version of the Contract which it then awards to the successful provider(s).

Recording of the route through which the contract was awarded

15.4 Page 2 of the Particulars of both the full-length and shorter-form versions of the Contract requires the commissioner to record whether the specific contract was:

- awarded under the Public Contract Regulations (PCRs);
- awarded under one of the PSR processes, and if so which one;
- awarded under the PSR urgent award exemption;
- awarded under the Procurement Act 2023; or,
- called off under a specific framework under regulation 18 of the PSR Regulations

15.5 This is necessary in part because the process used will affect the operation of GC13 (Variations). PSR Regulations 13-14 allow a broader range of "modifications" where the contract has been awarded under PSR direct award process A or B than where the contract has been awarded under other processes (including pre-PSR processes).

15.6 It is important that commissioners complete the information about the contract award process correctly, so we have set out some further explanation below.

15.7 There can only be one process for the award of a single contract, so the chosen process for award must be the same for all commissioners which are party to the contract in question and for all the services in scope of the contract.

15.8 Implementation of PSR should not:

- mean that different services always need to be dealt with in separate contracts; or
- discourage or prevent collaborative commissioning (whereby multiple commissioners award a single joint contract to a provider – see paragraph 13 above).

15.9 Commissioners will need to continue to make local decisions about which services they think it makes sense to bundle together into a single contract and about whether and when they wish to commission services jointly with others.

15.10 But, once those decisions have been made and if a joint contract is to be awarded, the commissioners must:

- jointly identify a single process which all of them will use to award the contract for the agreed bundle of services; and
- record this on page 2 of the Particulars.

15.11 In relation to contracts covering multiple services, note this FAQ answer from the PSR webpage:

"What happens if a relevant authority has a contract with an existing provider covering multiple health care services, some of which may fit under different provider selection processes?

Where appropriate to keep all services under a single contract, relevant authorities are advised to consider which single provider selection process is the most appropriate for the entire contract. For example, that the contract should be awarded using one of the direct award processes or the most suitable provider process or the competitive process in accordance with the procurement principles, and where appropriate the key criteria and the basic selection criteria. Relevant authorities must keep internal records of their decisions and their decision-making processes and must publish notices confirming their decision to award a contract."

15.12 It should be noted that there may also be a small number of mixed contracts, either for healthcare services and goods or healthcare services and non-healthcare services, where the appropriate procurement method might fall under the Procurement Act 2023. Commissioners should consider Regulation 3 of the Provider Selection Regime to determine whether the contract should be commissioned under the PSR or under the Procurement Act and may need to seek legal advice on this decision. If the contract is procured under the Procurement Act, commissioners may need to make amendments to the contract to comply with the provisions of the Act and should note the Act will imply further terms into that contract. Whichever procurement method is followed, if NHS-funded healthcare services are commissioned in the contract, then the form of contract used should be the NHS Standard Contract. See Section 7 above.

16 Contract expiry and notice requirements

16.1 We are often asked how, where contracts are approaching their expiry date, commissioners and providers should communicate with each other about their future intentions and what timescales apply, and some general guidelines on this are set out below.

- Where a contract is expiring, there is no contractual requirement on either party to give notice to terminate the contract or a specific service at the point at which the contract expires.

- Equally, there is no contractual requirement for commissioners to publish generic 'commissioning intentions' by a given date. Issuing of generic commissioning intentions documents, often aimed at a commissioner's providers collectively, rather than setting out specific information for individual providers, is at the discretion of the relevant commissioner.

- However, early communication of both commissioner and provider intentions is always good practice. In terms of a possible new contract for a new financial year, it is in both parties' interests to set out their intentions clearly in time for necessary negotiations, or other processes, to be completed before any new contract is intended to take effect.

- In advance of the expiry of a contract, the commissioner should as a matter of good practice, for instance, notify the provider that it no longer wishes to commission a specific service in the following year. In such a case, the requirements for the procurement process to be transparent and for the incumbent provider to share information about the services and the potential impact of handover to a new provider (for example, workforce information in expectation of TUPE applying), will mean that early communication of commissioner intentions is always required.

- Similarly, a provider should as a matter of good practice notify the commissioner that it no longer wishes to provide a particular service in the following year. If the service has been designated as a Commissioner Requested Service (CRS) (see paragraph 37 below), then restrictions on the provider's ability to withdraw provision of the service will apply, in line with CRS guidance.

- There will be other instances where either party is seeking changes, in a new contract for the following year, to services commissioned or to detailed contractual provisions (local quality and reporting requirements, say). As with in-year variations to agreed contracts, there is no specific period of notice which must be given for such changes; rather, the complexity of the issues involved and the time realistically needed to implement the specific changes proposed should drive the timescale for discussions. Both parties should remember that agreeing a contract tends to be a process of negotiation; it makes sense for all major changes which either party wishes to propose to be 'on the table' before detailed negotiations get under way, but it will often be possible to accommodate smaller changes after that point.

17 Changes in counting and coding practice

17.1 One instance where formal notification is required in advance of a new financial year, **even where a contract is expiring**, is in relation to changes in counting and coding practice, as set out in SC28. This requires that each party gives the other at least six months' notice of locally proposed counting and coding changes, with the change normally taking effect from the start of the following Contract Year. Further detail, covering how the financial impact of counting and coding changes should be managed, is set out in paragraph 44 below.

18 Contract duration

18.1 The NHS Standard Contract allows the commissioner to select the contract term it wishes. There is no default duration.

18.2 In principle, longer-term contracts can be a key tool for commissioners in transforming services and delivering significant, lasting improvements in service quality and outcomes. A longer-term contract allows time for providers to plan and deliver substantial service reconfiguration, for example. Where significant up-front capital investment is needed, a longer-term contract allows the provider to recoup this over the full duration of the contract. In both cases, offering contracts with a longer term has the potential to attract a wider range of providers, thus strengthening the pool of bidders from which the commissioner can select its preferred provider.

18.3 Equally, there will, of course, be situations where contracts with a shorter term may be appropriate, for example where the commissioning requirement is for a short-term or pilot service or where the service or supplier landscape is changing rapidly.

18.4 There is no nationally mandated limit to contract duration, nor is there a central approval process for contract terms beyond a certain duration. It is for commissioners to determine locally, having regard to the guidelines below, the duration of the contract they wish to offer.

- Commissioners will need 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 are able to 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. Contract length should be considered in conjunction with consideration of including any right to extend the contract (see paragraph 19) and/or the consequences of early termination (see paragraph 47).

- Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.

- Commissioners must ensure that the duration of any contract (and any proposed right to extend that period) is in compliance with their own standing financial instructions (SFIs) and other governance requirements, and that any approvals are obtained in line with those requirements. NHS England commissioners should note that NHS England's own SFIs set out specific arrangements for the approval, prior to advertisement, of procurement processes; commissioning teams should ensure that they review the SFIs in advance of advertisement to ensure that all required approvals have been obtained.

- Commissioners must consider their obligations under the Provider Selection Regime to act with a view to securing the needs of the people who use the services commissioned, improving the quality of those services and improving the efficiency with which they are provided, and to act transparently, fairly and proportionately. These obligations, separately or in combination, may lead commissioners to conclude that a contract of a longer or shorter duration may be appropriate.

18.5 Alongside flexibility of contract duration, the Contract:

- includes an explicit acknowledgement of the parties' rights to terminate the Contract or any Service by mutual agreement (GC17.1); and

- continues to include provisions for early termination of the Contract or a Service on a no-fault basis (in addition to rights to terminate when a party is in default), with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).

18.6 Where a multi-year contract is in place, both commissioner and provider are able to propose variations to the local terms (for example to effect annual reviews of local prices, service specifications and Local Quality Requirements). In respect of the updating of the national terms, see section 22 below.

19 Extension of contracts

19.1 Commissioners may wish to offer a contract with the possibility of extension – for example, a five-year contract term with the potential for an extension, at the commissioner's discretion, by a further two years or up to two years. Schedule 1C of the NHS Standard Contract is designed for that possibility and, if required, the commissioners should set out the optional extension period(s) and notice period there.

19.2 Even where the possibility of an extension has been provided for in Schedule 1C, any extension to the term of an NHS Standard Contract is a "modification" of that contract as defined in the PSR Regulations. As stated at paragraph 15.3 above, from 1 January 2024 onwards any changes to any healthcare contracts or framework agreements (whether awarded under the PSR or the previous procurement regime) have been governed by the PSR Regulations. So, the PSR Regulations will govern any extension to an NHS Standard Contract regardless of when that contract was entered into.

19.3 Commissioners should therefore consider PSR Regulations 13 and 14, and the sections of PSR Statutory Guidance, dealing with modification of contracts and framework agreements during their term and with urgent awards and modifications, when either considering including an option to extend in a contract or considering actually extending a contract.

19.4 If a contract was entered into before the commencement of the PSR and already includes a populated Schedule 1C, it will not be necessary to vary that Schedule to reflect the PSR.

19.5 The PSR permits modifications that are "clearly and unambiguously provided for in the contract" (regulation 13(1(a) of the PSR Regulations). The optional extension provisions at Schedule 1C of the 2026/27 NHS Standard Contract are intended as a template to include a clear and unambiguous modification to the contract (the modification being the extension of the term). They may be amended to suit local requirements – for example, to provide the right to extend in relation to specific services and/or commissioners only, or for different extension periods for different services and/or commissioners. But we recommend that commissioners take legal advice if considering departing from the template wording at Schedule 1C.

19.6 While regulation 13(1)(a) does not itself limit the duration of an extension to the contract term which can be clearly and unambiguously provided for in the contract, it is essential that this regulation is not misused. Remember that the overriding principles of the PSR are that relevant authorities are to:

- act with a view to securing the needs of the people who use the services, improving the quality of the services, and improving the efficiency of in the provision of the services;
- ensure decisions about which organisations provide health care services are robust and defensible, with conflicts of interest appropriately managed; and
- adopt a transparent, fair, and proportionate process when following the PSR.

If commissioners are considering making provision in their contract for a potential extension, they should take these overriding principles into account. For example, given these overriding principles, the commissioners may want to provide for a single extension, or a limited number of short-term extensions, of an aggregate period no longer than the original contract. This will provide the opportunity for the commissioners to reassess the provider market when the end of the original term, and of any extension period, is approaching and consider at each point whether another provider is in a better position to achieve the 'key criteria' set out in regulation 5 of the PSR Regulations.

19.7 Where provision for extension is made in a contract, the extension can then be effected by the co-ordinating commissioner (on behalf of all commissioners which are party to the contract) giving notice to the provider that it wishes to implement the extension.

19.8 Where a notice to extend is given, the contract term is automatically extended; no contract variation is necessary to effect it, and the provider may not refuse an

extension (though it may of course still give notice to terminate the contract under the provisions of GC17).

19.9 Note that the Schedule 1C template wording assumes that any extension effected under the option will (unless adapted locally to say otherwise – see 19.5 above) apply to all commissioners which are party to the contract, and to all services commissioned under it.

19.10 But, as stated at paragraph 3 of Schedule 1C, an option to extend may be exercised in conjunction with a contract variation if required. So, either before or immediately after the option is exercised, the parties may agree (subject to the terms of GC13 and to PSR regulations 13 and 14) to vary the service specifications or other locally-populated elements of the contract – and it will then be the scope and terms of the contract as varied which apply to the extended term.

19.11 Whether or not the Schedule 1C text is included, the contract term may be extended if any of the other circumstances under which modification to the contract is permissible under regulation 13 or regulation 14 of the PSR Regulations apply. We recommend that commissioners take legal advice if considering an extension to the contract term in any circumstances or on any terms other than those set out clearly and unambiguously in Schedule 1C to their contract.

19.12 Note that the PSR Regulations require the commissioner to submit a notice of the extension (i.e. the modification to the contract) for publication on the UK e-notification service:

- if it is made under regulation 13 and the cumulative value of modifications made since the start of the contract is £500,000 or more; or
- if it is made in a situation of urgency under regulation 14.

20 Heads of Agreement

20.1 We are sometimes asked about Heads of Agreement and whether these have a place in the negotiation of new contracts.

20.2 Heads of Agreement are different to contracts. They are typically pre-contract agreements and are not intended to create a binding arrangement between the parties (which is why they generally include the caveat “Subject to Contract”). In complex procurement and contract negotiation scenarios, Heads of Agreement (sometimes also referred to as Heads of Terms) may be useful as a way of documenting progress towards intended signature of a binding contract – but in most NHS commissioning situations, both parties will be better advised to focus on agreeing and signing the actual contract itself.

21 Signature of contracts and variations

21.1 A contract must be signed by an appropriately authorised signatory of each party to it. Where a group of commissioners wishes to enter into a contract with a provider, each of the commissioners must sign the contract and cannot delegate this responsibility to another commissioning body. By "signed" we mean (i) signed physically, in hard copy form, or (ii) subject to our further guidance below, signed electronically.

21.2 We have previously recommended that contracts (and other contractual documents) are signed physically, in hard copy form, by the authorised signatory of each party, unless the parties have taken legal advice on appropriate governance arrangements and on the risks involved (but see our updated guidance below). As set out in GC38, hard copy signatures can be applied to original and counterpart copies of the relevant document where necessary. Such hard copy signatures can be physically returned to the co-ordinating commissioner by post but can alternatively be scanned and returned to the co-ordinating commissioner by email. The co-ordinating commissioner should maintain a record of all contract signatures and should provide copies to other commissioners for audit purposes.

21.3 We recognise that the collection of signatures from commissioners is a time-consuming process. Variations may therefore be signed by the provider and the co-ordinating commissioner (on behalf of all commissioners) only, rather than by all commissioners (see GC13.4). Commissioners must therefore ensure that their collaborative agreements set out very clear arrangements through which Variations are agreed amongst commissioners, prior to signature by the co-ordinating commissioner. The co-ordinating commissioner must maintain a record of evidence that each variation has been properly approved by all commissioners (whether or not they are directly affected by the variation – because all are parties to the contract being varied) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.

21.4 We recognise that use of electronic signatures (via appropriate internal governance procedures and IT software) for signing of legal documents is becoming common in some areas of commerce, and this practice has become much more widespread both as a necessary consequence of the Covid-19 pandemic and as a result of the Lord Chancellor's confirmation of the Government's agreement with the Law Commission's report on Electronic Execution of Documents in March 2020. We continue to recommend that parties do not use or accept electronic signatures for signing of contracts (or other contractual documents) without having taken their own legal advice on appropriate governance arrangements and on the risks involved and having consulted their own organisation's guidance and governance documents on the use and acceptance of electronic signatures.

21.5 Here are some general pointers on use and acceptance of electronic signatures in relation to the contracts, sub-contracts and variations which are the subject of this Technical Guidance. They should not be taken as a substitute for parties taking their own legal advice and consulting their own organisation's guidance and governance documents, nor as being applicable to all legal documents.

- An electronic signature is capable in law of being used to sign a document provided that: (i) all parties to the document intend that that electronic signature will authenticate the document on the relevant party's behalf; and (ii) any formalities (e.g. governance requirements) relating to the signing of that document by that party are satisfied. If these conditions are met, the document will be deemed signed just as it would if signed by hand in ink.

- Generally, only the following forms of electronic signature should be considered as 'safe': (i) the use of electronic signature software platforms, and (ii) uploading scanned photos of signatures.

- Security measures can help to provide evidence as to who exactly signed the document and when. Such security measures can include the signatory signing the document from their own account or a computer that they had to use a personal password, pin or encryption key to access. Electronic signature platforms can also give further evidence as to IP addresses and the time and date of signature.

- Documents may be signed electronically by a delegate of the authorised signatory, but only if the authorised signatory has given the delegated person the authority to do so. It is advisable to have an audit trail of confirmation of this delegated authority.

- A combination of wet signatures and electronic signatures can be used by different parties on signing. If the document is signed electronically by both parties, it is not necessary to keep a hard copy. Documents can be electronically signed in counterpart or the same document can be signed electronically by all parties.

22 Updating non-expiring contracts

22.1 Where a multi-year contract is in place and continues into a new financial year, the updated General Conditions and Service Conditions, once published online by NHS England in final post-consultation form, **will take automatic effect from 1 April of the new financial year, without any need for local action**. (Further detail about these online publication arrangements can be found in paragraph 33 below.)

22.2 In this situation, the commissioner and provider are very likely to need to agree a Variation locally between them to update aspects of the Particulars (prices and contract values, for instance). We have published a model variation template and guidance for 2026/27, offering two options for updating multi-year contracts.

- The first will allow for a full set of Particulars to be updated, attached to the Variation Agreement and exchanged. This will be appropriate where there are changes to the local content of large number of the Schedules.

- The second simpler option will be appropriate where most Schedules can be left unchanged from 2025/26 to 2026/27, but the parties need to update a small

number of Schedules (payment, the Indicative Activity Plan or SDIPs, for example).

22.3 We have also shared the slides and recording from our webinar 'Guidance on the contract variation process' on our page on the FutureNHS platform, and this provides a useful introduction to the process of updating a non-expiring multi-year contract.

23 Resolution of disputes

23.1 Arrangements for resolution of disputes which arise once a contract has been agreed are dealt with under GC14.

23.2 The Revenue, Finance and Contracting Guidance for 2026/27 describes the timescale and process for resolving disputes over the agreement and signature of new contracts with Trusts for 2026/27.

24 What happens when there is no signed contract in place?

24.1 There may be instances where commissioners and providers have not signed a new contract by the time at which the current contract expires – but, because the services being provided are crucial for the local community, they must continue to be delivered.

24.2 In this situation (assuming services continue to be provided and paid for), a contract will be implied between the parties. The local terms of that implied contract will reflect what can be inferred as having been agreed between them – based on correspondence between them, notes of meetings, drafts exchanged and so on. It would be reasonable to assume that the implied contract would incorporate the nationally drafted terms of the NHS Standard Contract for the relevant year (since those are the only terms on which NHS commissioners are permitted to commission the services in question).

24.3 However, in the absence of clear evidence of terms agreed, aspects of the implied "deal" between the parties may be uncertain. For this reason, it is very important that the parties continue to make every effort to reach agreement and sign a contract as soon as possible.

25 Low Volume Activity and Non-Contract Activity

25.1 Low Volume Activity (LVA) and Non-Contract Activity (NCA) are terms used to refer to NHS-funded services delivered to a patient by a provider which does not, at the point at which those services are delivered, have a written contract in place with that patient's responsible commissioner, but which does have a written contract for the delivery of that service in place with at least one other NHS commissioner.

Low Volume Activity arrangements

25.2 LVA arrangements apply to certain relationships between ICBs and NHS Trusts / NHS Foundation Trusts. Full detail will be set out separately in the 2026/27 NHS Payment Scheme.

Non-Contract Activity arrangements

25.3 NCA arrangements will operate as described in the remainder of this paragraph 25. They will be relevant for flows of activity between ICBs and non-NHS provider organisations where no written contract is in place, as well as for a small number of ICB / Trust activity flows specifically excluded from the LVA arrangements.

25.4 We receive many queries about NCA arrangements. Appendix 4 of this guidance deals with common NCA scenarios.

When can an NCA approach be adopted?

25.5 By far the most common situation in which an NCA approach can be used is where patient choice of provider applies. A provider of elective services may have a written, signed contract in place with one ICB, but may then find that its services attract referrals, under the legal right of patient choice, from other ICBs with which it does not have a written, signed contract. Where this happens, the provider and those other ICBs may reasonably operate on an NCA basis. (Further detail about patient choice is set out in paragraphs 25.8-12 below, and paragraphs 25.13 onwards then deal with the contractual terms which apply under an NCA approach.)

25.6 Otherwise, NCA arrangements will only be appropriate, and should only be necessary, in a limited number of situations. For instance, one ICB may ask a non-NHS provider of patient transport services, which holds a contract with another ICB, to undertake a single journey for it, to repatriate a patient admitted to a distant hospital as an emergency. An NCA approach will be appropriate in such a case.

25.7 Bespoke, high-cost, locally priced residential placements of individual patients should always be covered by a written contract in the form of the NHS Standard Contract. Reliance on an NCA approach in this situation creates too great a risk of uncertainty as to what has been agreed. Agreed details can be set out in individual placement agreements called off under the contract, as described in paragraph 27 below.

Legal right of choice of provider

25.8 Most NCA happens where patients are exercising their legal right to choose their provider, and so we have set out some brief explanatory background on patient choice below.

25.9 Revisions to regulations relating to patient choice, including patients' rights to choose their provider, came into effect on 1 January 2024, alongside those which established the NHS Provider Selection Regime (see paragraph 15 above). At the

same time, the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (which formed part of the previous "choice" regime) were revoked.

25.10 NHS England has published updated patient choice guidance, providing advice on the regulations and describing how it will support commissioners to ensure compliance with them.

25.11 Commissioners and providers should refer to this updated guidance, but the basic principles remain the same as previous policy in this area.

- Commissioners (ICBs and NHS England) must ensure that when a GP, dentist or optometrist makes an elective referral for a first outpatient appointment to a service led (for physical health) by a consultant or (for mental health) by a consultant or other mental health care professional, the patient can choose from any clinically appropriate health service provider which has a contract with a commissioner for the particular service required. That contract for that service (referred to in the regulations as a "qualifying contract") must be an NHS Standard Contract which is signed (which means signed by all parties to it) and in effect (which means that it has been dated and its "Effective Date" has passed) before the date on which the referral is made.

- The judgement on the clinical appropriateness of the referral and of the health service provider / team is for the referring clinician to make. The patient must also be able to choose any clinically appropriate team led by a named consultant (or, for mental health services, other health care professional) employed or engaged by the provider.

- The Contract therefore continues to include provisions at SC6.13 (SC6.2 in the shorter-form version) which require that providers must accept all referrals / presentations which give effect to a patient's legal right of choice (or which are for emergency treatment) – even where the patient's responsible commissioner is not a direct party to the provider's contract. SC6.16 (SC6.5 in the shorter-form) then makes clear that, in other circumstances, a provider has no entitlement to be paid for providing services to patients whose responsible commissioner is not a party to the contract.

- For the legal right of choice to apply to a particular service under the Standing Rules, the provider must have been commissioned to provide that service by at least one ICB. But this legal right of choice only applies to the service as commissioned – that is, on the basis specified in the provider's contract with the first ICB. So, if the provider has a contract for service X to be provided in location A, that of itself does not allow that provider, on a Non-Contract Activity basis, to open a new facility and offer service X in location B, a hundred miles away. Neither does it of itself allow that provider, on a Non-Contract Activity basis, to offer service Y in location A or in location B. SC6.16 (SC6.7 in the shorter-form) makes this explicit. (See paragraph 36.5 below for advice on recording service delivery locations within specifications.)

25.12 Detailed enquiries on the operation of patient choice and the relevant regulations can be sent to england.choice@nhs.net.

What contractual terms apply under an NCA approach?

25.13 The regulations state that the terms of the qualifying contract (which the provider holds with the host ICB) apply to the activity which it undertakes, under patient choice, for an NCA ICB. SC6.16 (SC6.5 in the shorter-form) now mirrors this.

25.14 What does that actually mean in practice?

- It does not mean that the NCA ICB becomes a party to the qualifying contract held by the host ICB.

- Rather, a new and separate contract is implied between the provider and the NCA ICB only. That separate implied contract is deemed to incorporate all of the national terms of the NHS Standard Contract as well as the agreed local terms of the qualifying contract as at the time the Non-Contract Activity is carried out (i.e. taking into account any variations to it which have come into effect) – the Service Specification in Schedule 2A, for instance, the Local Prices (if applicable) in Schedule 3C, the Local Requirements Reported Locally in Schedule 6A.

- But, because the implied contract is separate, the NCA ICB is the sole commissioner under it and is not bound by actions or decisions which the host ICB may have taken under the qualifying contract. The host ICB will be the co-ordinating commissioner under the qualifying contract which it itself holds with the provider – but it is not the co-ordinating commissioner under the separate implied NCA contract. Instead, under that separate implied contract, all of the contractual rights and obligations which fall to a commissioner or to the co-ordinating commissioner fall to the NCA ICB alone.

- It follows that the NCA ICB is entitled to the protections of the various contract management processes set out in the General and Service Conditions and can apply those processes itself. It can, for instance, initiate action to address unsatisfactory performance by the provider using GC9, request information from the provider under SC28 or notify the provider of Prior Approval Schemes under SC29. (We deal with the question of approval of sub-contractors under NCA arrangements in Appendix 4.)

25.15 Further guidance on common NCA scenarios is set out in Appendix 4, but note in particular that:

a) services will be delivered in accordance with the service specifications and other terms and conditions of the provider's contract with its host commissioner;

b) prices for services will be either the relevant unit prices (where these apply and subject to any locally agreed adjustments) or (where there are no applicable unit prices listed in the NHS Payment Scheme) the local prices set out in the provider's contract with its host commissioner(s) – but noting that, where the host contract provides for a service to be paid for as part of a block or similar arrangement, the price payable for the NCA will be (a) the unit price, where there is one for that service or (b) a local price to be agreed between the

provider and the responsible commissioner in accordance with NHS Payment Scheme guidance;

c) Indicative Activity Plans set by the host commissioner will not apply to NCA activity, and NCA commissioners should seek to agree or set their own Indicative Activity Plans where activity is of a sufficient volume to require management. Similarly, Activity Management Plans set under the qualifying contract will not apply to NCA activity; NCA commissioners should follow the contractual Activity Management processes on their own behalf if required;

d) arrangements for submission of activity datasets, invoicing and payment reconciliation should follow NHS Payment Scheme guidance and the terms and conditions set out in the NHS Standard Contract; this means that non-NHS providers must invoice for NCA monthly in accordance with either SC36.23 or SC36.24 (full-length Contract) or SC36.17 (shorter-form Contract);

e) commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements – but must, if they intend to do so, contest payment within the timescales set out in SC36.30 (full-length) and SC36.22 (shorter-form);

f) commissioners and providers should work together in good faith to minimise disagreements relating to prices and payment for NCA, but any formal disputes must be resolved in accordance with the dispute resolution procedure set out in GC14 of the Contract; and

g) while a commissioner dealing with a provider on an NCA basis may take some comfort from the fact that that the provider's host commissioner should be holding that provider to account under the terms of the host's contract, it should always remember that it is not the host's role to monitor the performance of services under the NCA commissioner's implied contract. That is an entirely separate contract, which is for the NCA commissioner to monitor and manage, using the provisions of SC29, GC9 and so on, as necessary.

25.16 From a public value-for-money perspective, it is very important that, where a commissioner receives an invoice for the first time from a provider with which it does not have a written contract, it checks the basis on which that invoice is being submitted before making any payment in respect of that invoice, rather than simply paying it without question. Checking that the provider does indeed hold an NHS Standard Contract with another commissioner, which properly entitles it to provide those specific services to the first commissioner's patients, at the location at which they have been provided, and on an NCA basis, will be a necessary first step. A provider wishing to provide services on an NCA basis must, on request, share with the NCA commissioner the full (including pricing) written, signed and dated contract / contracts it holds with another commissioner / other commissioners and on which it is relying in order to undertake NCA – and, from 2025/26 onwards, this became a specific obligation under SC6.15 (SC6.4 in the shorter-form).

Acceptance of referrals by NCA providers

25.17 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.

25.18 The Contract includes a specific requirement on providers (SC6.13.2 in the full-length version, SC6.2.2 in the shorter-form) to accept every referral, regardless of the identity of the responsible commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the responsible commissioner for the patient affected is a party to a written contract with the provider. (Note, however, the restrictions which apply in respect of GP referrals to elective acute services not made via e-RS – see paragraph 42.19 below.)

25.19 There is also an equivalent provision in relation to the acceptance of emergency referrals and presentations which are within the scope of the services it provides (SC6.13.3 full-length, SC6.2.3 shorter-form). Again, this requirement applies whether or not the responsible commissioner for the affected patient is a party to a written contract with the provider. There will be instances where a provider cannot safely accept an emergency referral, and so should reject it, and the Contract wording makes provision for this.

25.20 These provisions continue to apply to Trusts operating under the LVA arrangements described in paragraph 25.2 above, as well as to non-NHS providers, and can be enforced by the responsible commissioner of any affected patient, either through the co-ordinating commissioner for the provider's main contract or directly via GC29.1 (Third Party Rights). It is therefore not acceptable (and is a breach of contract) for a provider, with or without the support of its main local commissioners, to adopt a systematic policy of rejecting "choice" referrals or emergency presentations from distant ICBs (including those operating on an NCA or LVA basis), whilst continuing to accept those from within its local area. (In extreme situations, where a provider believes that it cannot safely manage the volume of choice referrals it is receiving, it may ask the co-ordinating commissioner to consider suspending **all** (or all non-urgent) new referrals, **from all commissioners which are party to the qualifying contract in question,** into the affected service for a time-limited period. Suspension (under GC16: note the contract definition of "Suspension Event" – see paragraphs 47.11-13 below) can only be initiated by the co-ordinating commissioner. If the co-ordinating commissioner agrees to a suspension, the co-ordinating commissioner and provider can then work jointly on managing the impact of the suspension, in terms of communicating with patients, referrers and other affected providers, with the aim of ensuring that patients can continue to be cared for safely and appropriately.)

25.21 Conversely, we also set out clearly (SC6.16 in the full-length Contract, SC6.5 in the shorter-form version) that the existence of a contract with one commissioner does not automatically entitle a provider to accept referrals in respect of, provide services to, nor to be paid for providing services to, individuals whose responsible commissioner is not a party to the contract, except (where appropriate) where such an individual is exercising their legal right to choice of provider or where necessary for the individual to receive emergency treatment. (See paragraph

25.19 below for further detail on the application of the legal right of choice.)

Commissioner prior approval for NCA activity

25.22 In this context, the following arrangements apply, within England, in terms of commissioner approval processes for NCA.

a) No prior commissioner approval is required for emergency treatment on a non-contract basis.

b) Except where necessary under paragraph 25.24 below, no prior commissioner approval is required for consultant-led elective care or in the case of mental health, services led by a healthcare professional, where the patient has exercised their legal right of choice of provider. A GP, dentist or optometrist referral is required in such cases, however: self-referral is not sufficient.

c) In other circumstances than those set out in paragraphs a) and b) above, there is no presumption that a provider may see and treat patients, on a non-contract basis, and expect to be paid by commissioners. Commissioners have the right to determine which services they wish to commission and from which providers. Rather, the provider must seek prior authorisation from the responsible commissioner before assessing and treating the patient. Where prior authorisation is not granted, commissioners are under no obligation to pay for activity which is carried out by providers on a non-contract basis.

Under the LVA arrangements for Trusts, described in paragraphs 25.2 above, there is no requirement to seek prior authorisation.

25.23 For elective NCA referred into an English provider across a UK border, the provider is advised to seek and obtain prior approval from the relevant NHS body in Scotland, Wales or Northern Ireland before providing care or treatment.

25.24 The NHS Standard Contract allows Prior Approval Schemes to be notified to a provider via its co-ordinating commissioner. These Schemes typically set out commissioner policies for a certain service or treatment (a high-cost drug, for instance, or a treatment of perceived limited clinical value). Further detail on Prior Approval Schemes is set out in paragraph 42.8-13 below. In the context of NCA, the key points to note are that:

- where a provider is operating on an NCA basis, under an implied contract with a particular ICB, that ICB may notify it of its own specific Prior Approval Schemes, and the provider must then comply with them; but the ICB cannot expect the provider to be aware of its Prior Approval Schemes without having notified it of them; and

- a Prior Approval Scheme must not be used to restrict a patient's legal right of choice of provider.

Long-term reliance on NCA arrangements

25.25 In our view, NCA arrangements are a poor substitute for the discipline of written, signed contracts. Having a written contract will always be more robust and clearer than having an implied contract on an NCA basis; there will be less scope for misunderstanding and dispute with a written contract in place. It is always open to a commissioner to agree a written contract with a provider (awarded in accordance with the NHS Provider Selection Regime), and the patient choice regulations make specific provision for a provider to approach any ICB to be "qualified" (and, if successful, to be awarded a contract) to provide a patient choice service.

25.26 Our advice therefore remains that written contracts, using the NHS Standard Contract format, should be put in place between commissioner(s) and provider in all cases where there are established flows of patient activity with a material (even if unpredictable) financial value. If this is done using the multi-ICB collaborative contracting approach described at paragraph 13 above, the result will be a more efficient, effective and joined-up set of contractual arrangements.

25.27 We are aware, however, of situations in which – despite an established flow of activity – either provider or commissioner is reluctant to move away from an NCA relationship, believing that the NCA approach will somehow best serve its interests. This is misguided for the following reasons:

- Relying heavily on an NCA approach is inherently risky for a provider. If a provider holds only one written signed contract for all of its activity, including NCA, then were that contract to expire or be terminated, the provider would have no basis on which to accept NCA under patient choice;

- A provider may believe that an NCA approach means that it is less accountable to its NCA commissioner than it would be under a written, signed contract and that its NCA commissioner is powerless to use contractual levers to hold it to account. This is simply not the case. As described at paragraph 25.14-15 above, all of the contractual levers which are available to any commissioner or to the co-ordinating commissioner can be used by an NCA commissioner. It can for instance request information from the provider under SC28, require reports from it under Schedule 6A, manage activity under SC29, contest payment to it under SC36 and manage its performance under GC8-9;

- But equally, a commissioner will be much better placed to ensure that the requirements of its local population are being met if it can specify those requirements as part of a written, signed contract; it can then refer directly to its own desired referral and discharge protocols or shared care arrangements, for example.

26 Promoting collaboration and contracting for integrated services

26.1 The principle that different providers should collaborate more closely with each other, providing their services in an integrated way to best meet the needs of patients, has been a key driver in the move towards NHS system working over

several years – and statutory arrangements were of course established by the Health and Care Act 2022. Contractual models for driving better integration of services continue to have relevance, though, and this section describes some of the available approaches. (Note that the proposed use of complex or novel contractual models for integration may trigger a requirement to undergo an NHS England assurance process.)

26.2 At the simplest level, in situations where it is important for different providers to join up their individual services around patients' needs, commissioners can specify in the separate contracts with each provider what is required of each in terms of its interaction and interface with one or more other providers. This can be a means of ensuring that referral or transfer from one provider to another happens smoothly, for instance, with no confusion as to who is responsible for what – or of avoiding wasteful duplication. Service specifications and referral processes can be aligned and dovetailed with each other, and payment and incentive regimes across contracts can be aligned and directed towards what is best for the patient group served by the providers collectively.

Contracting for integrated primary and secondary care

26.3 If a commissioner wishes to place a single contract for integrated secondary care and primary medical services, it may do so using the NHS Standard Contract with the addition of Schedule 2L (Provisions Applicable to Primary Medical Services). This schedule introduces the further provisions required in order to make the Contract compliant with the Alternative Provider Medical Services (APMS) directions. With this addition, the Contract will be both an NHS Standard Contract and an APMS contract. A template form of those further provisions, for inclusion in Schedule 2L where appropriate, is available on the NHS Standard Contract webpage, along with guidance about their use. This schedule will be updated later in this financial year for use in 2026/27.

26.4 The APMS-compliant version of the NHS Standard Contract (i.e. one including template APMS provisions) is likely to be useful where, for instance, a commissioner wishes to commission an integrated NHS 111 and out-of-hours primary medical service from the same provider under a single contract.

Integrated Health Organisations

26.5 The 10 Year Health Plan for England, published in July 2025, sets out the intention to create a new opportunity for NHS Foundation Trusts to hold whole or part of the health budget for a defined local population as an integrated health organisation (IHO).

Work has begun to develop the contractual arrangements that will support these new opportunities. It is likely that these will be based on the existing NHS Standard Contract with developments to suit the specific arrangements for IHOs. Further information will be provided during 2026/27 and any new contract model is likely to be published for 2027/28.

Lead provider and alliance models

26.6 The NHS Standard Contract can readily be used as a "lead" or "prime" contract. Under this model, the commissioners enter into a contract with a single lead provider / prime contractor. That contract allocates risk and reward as between the commissioner and the prime contractor. The prime contractor then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The prime contractor remains responsible to the commissioners for the delivery of the entire service, and for the co-ordination of its 'supply chain' (i.e. its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime contractor is likely to be a provider of clinical services itself, but it could sub-contract all but the co-ordination role. The optional schedule of primary care provisions (see paragraph 26.3 above) enables the Contract to be used as a prime or lead contract under which a package of primary and secondary care services may be commissioned.

26.7 The fact that one provider assumes the role of prime or lead contractor, and therefore takes the lead in terms of accountability to and communication with the commissioners, need not mean that the other providers involved in delivery of the service are entirely subservient to the prime contractor. A prime contract and the sub-contracts to it can be underpinned by an agreement (similar in many respects to the alliance agreement mentioned below) between all of the providers, which sets out how they are all to be involved in decision-making and in determining how services are to be provided and resources allocated between them.

26.8 An alternative to a prime or lead provider model is an alliance approach, under which multiple contractors are bound together to pursue shared aims and objectives. The key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability; contracting for outcomes; and an expectation of innovation. Some forms of alliance contracting are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to a single commissioning contract – but the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts (and, where appropriate, other forms of commissioning contract). We have published on FutureNHS a model Alliance Agreement and supporting materials which commissioners may use as a starting point for development of their own alliancing arrangements with providers. (Please note that you will need to join the System Design Enablers workspace in order to be able to see the documents).

26.9 If you would like to discuss any of these approaches, please contact us via england.contractsengagement@nhs.net.

27 Use of the Contract for call-off arrangements

27.1 We know that many commissioners have successfully used the Contract in the context of a framework for, for example, care home placements. One way of doing this is where an NHS Standard Contract is entered into with each provider appointed to the framework, with processes for "call-off" of activity set out in Schedule 2A and prices/day rates for activity (perhaps based on a needs

assessment) set out in Schedule 3C. The Commissioner then raises a purchase order (PO) or individual placement agreement (IPA) for each placement, and the PO or IPA references the Contract which is in place between the parties. (To be clear, a PO or IPA may only be used when there is an NHS Standard Contract in place with the provider; they must not be used in isolation.) Either the full-length or the shorter-form version would be fit for purpose in this context – but, as noted above, the same form of contract must be used with each provider appointed under a framework procurement. A model IPA is available on the Individual Placement Agreement publication page.

27.2 We strongly recommend that commissioners take legal advice if considering their own framework procurement.

28 Contracting approaches to support personalised care

Universal Personalised Care

28.1 Ensuring that patients receive personalised care tailored to their individual needs is at the heart of the NHS Long Term Plan, and NHS England has published a detailed programme for the development of more personalised approaches (Universal Personalised Care: Implementing the Comprehensive Model).

28.2 The Contract includes provision for inclusion of a Development Plan for Personalised Care at Schedule 2M. This can be used to set out actions which the commissioner and provider will take to give patients greater choice and control over the way in which their care is delivered. This is an optional schedule, but its use will be appropriate in many local contracts and is strongly encouraged. Advice on completion of the schedule is included in the Particulars.

Personal health budgets

28.3 Personal health budgets (PHBs) are one important tool in the delivery of personalised care. General information regarding PHBs is available at https://www.england.nhs.uk/personal-health-budgets/. Under current legislation, certain patient groups have a legal right to a PHB, and commissioners and providers should ensure that, as a minimum, these rights are upheld and promoted. Legal rights to have a PHB are currently in place for:

- adults eligible for NHS Continuing Healthcare and children / young people eligible for continuing care;
- people eligible for NHS wheelchair services; and
- people who require aftercare services under section 117 of the Mental Health Act.

Schedule 2M can be used to set out plans and operational arrangements for the implementation of PHBs.

28.4 The guidelines below are intended to help commissioners determine the appropriate contracting model for each of the three options of managing a PHB,

but commissioners will need to exercise local discretion and common sense to ensure that a proportionate approach is adopted.

- **Notional budget.** Where an NHS commissioning organisation itself commissions healthcare services funded by a PHB on behalf of an individual (a notional budget), use of the NHS Standard Contract is likely to be appropriate. Individuals' needs will be established through the care and support planning process, and the commissioner may need to contract with a provider to provide part or all of a package of care for one individual patient or for a number of patients, funded from a PHB in each case. The contract should reflect how the needs of each individual patient will be met from his/her PHB. Individual care packages can be handled within the contract as set out at paragraph 12.3 above.

- **Third party.** Where a PHB is being managed by a third party independent of the commissioner, (for example where the third party is a trust fund set up on behalf of the individual), the commissioner will contract with the third-party organisation to organise, purchase and be responsible for, the patient's care and support. In these instances, it may be appropriate to use the NHS Standard Contract to govern the relationship between the commissioner and the third-party organisation managing the PHB, but the commissioner should consider on a case-by-case basis what approach to take. When the third party purchases the services and products on behalf of the individual as agreed in their care and support plan, the NHS Standard Contract should not be used.

- **Direct payment.** Where a commissioner makes a direct payment to an individual (or their representative or nominee) who then holds the PHB and contracts directly with a provider, the individual (or their representative or nominee) will not need to use the NHS Standard Contract, nor is there a need for a contract between the commissioner and the provider. The care and support plan, which is an agreement between the ICB and the individual, will set out the details of the needs to be met and the outcomes to be achieved by the services to be provided.

28.5 PHBs may in some cases be spent on non-clinical services or items not routinely commissioned by the NHS. Where this is the case, under the notional budget or third party options, use of the NHS Standard Contract is not appropriate; rather, the commissioner will wish to use the NHS terms and conditions for the procurement of goods and non-clinical services.

28.6 Funding for PHBs should not be about new money but money that would have been spent on that person's care using already commissioned NHS services. However, the funding that could be offered as a PHB may often be included in existing contracts, with many of these operating on a block basis. It is therefore important to ensure that both a clear strategic direction and relevant processes are in place to enable the freeing-up of funding for PHBs. From a contracting perspective, this can be addressed through agreement of appropriate local provisions in Schedule 2M (whether negotiated annually or through variations). Therefore, alongside the technical steps to establish PHBs, commissioners also need to work closely with providers to influence change and improve services in key areas so that they are more responsive to the needs of individual users. This

should be set out clearly in the local offer for PHBs.

The importance of relationships

28.7 Once entered into, the contract is a key lever for commissioners in delivering high-quality and cost-effective services. However, the contract in isolation will not achieve this. An effective working relationship between commissioner(s) and provider is a key element of successful contracting.

28.8 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues – but nor will it be one where each party focusses solely on protecting what is perceives to be its own narrow, individual interests.

28.9 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioners and providers across a healthcare system:

- have a shared vision for services with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;
- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;
- behave respectfully towards each other, encouraging a "just culture" of fairness, openness and learning;
- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and
- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other.

29 Contracting fairly

29.1 The contract is an agreement between the commissioner(s) and the provider. Once entered into, the contract is a key lever for commissioners in delivering high-quality, safe and cost-effective services. However, the contract in isolation will not achieve this. An effective working relationship between commissioner(s) and provider is a key element of successful contracting. A key aim of the Health and Care Act 2022 is to promote local partnership working, and NHS England has published guidance for ICBs on governance and working arrangements. In 2025, NHS England published a Model ICB Blueprint to further clarify the roles of ICBs.

29.2 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues for fear of upsetting each other – but nor will it be one where each party focusses, aggressively and continuously, on protecting what is perceives to be its own narrow, individual interests.

29.3 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioners and providers across a healthcare system:

- have a shared vision for services, with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;
- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;
- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and
- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other.

29.4 (This is the approach that is encapsulated in our model System Collaboration and Financial Management Agreement – see paragraphs 4.6-7 above.)

30 Advice and support

30.1 If you have questions about this Guidance or the operation of the NHS Standard Contract in general, please contact england.contractshelp@nhs.net.

30.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.We have a page on the FutureNHS platform, where we post slide packs from, and recordings of, different webinars we have run on contracting topics. See https://future.nhs.uk/NHS_Standard_Contract. Webinars are available which cover the following:

- introduction to the NHS Standard Contract
- completing the Schedules in the NHS Standard Contract (two separate webinars)
- sub-contracting under the NHS Standard Contract
- the contract variation process
- Non-Contract Activity.

30.3 Other useful contacts are set out below.

- Queries relating to *Who Pays?* can be sent to england.responsiblecommissioner@nhs.net

- Queries about the NHS Payment Scheme can be sent to pricing@england.nhs.uk

- Queries about the NHS Provider Selection Regime can be sent to psr.development@nhs.net

- Queries about the NHS terms and conditions for the procurement of goods and non-clinical services can be sent to england.nhseCommercialGovernance@nhs.net

- Queries on patient choice can be sent to england.choice@nhs.net

- Queries on GP Contracts can be sent to england.gpcontracts@nhs.net

Section B Completing and using the Contract

31 Content of this section

31.1 The aim of this part of the Technical Guidance is to offer advice about both how key sections of the Contract should be completed and how the main contract management processes should be used in practice.

31.2 For each topic within this section, we highlight where specific changes have been made to the Contract for 2026/27. Please refer also to Appendix 1, which goes through the different elements of the Particulars on a line-by-line basis, describing what each is for and how each should be completed.

31.3 The Technical Guidance is written primarily with the more complex, full-length version of the Contract in mind. Where appropriate, at the start of each section, we highlight briefly any key considerations in relation to the shorter-form Contract.

31.4 We have shared the slides and recording from our webinars 'Introduction to the NHS Standard Contract and 'Completing the Contract Schedules 1 and 2' on our page on the FutureNHS platform, and these provide a useful introduction to many of the sections below.

32 Structure of the NHS Standard Contract

> The shorter-form Contract uses the same three-part structure as the full-length version.

32.1 The Contract is divided into three parts.

- **The Particulars.** These contain all the sections which require local input, including details of the parties to the contract, the service specifications and schedules relating to payment, quality and information.

- **The Service Conditions.** This section contains the generic, system-wide clauses which relate to the delivery of services. Some of these apply only to particular services. The column in the right-hand margin identifies which clauses apply to which service categories; clauses which are not relevant in a particular contract should be "read over" (see paragraph 34 below).

- **The General Conditions.** This section contains the fixed standard conditions which apply to all services and all types of provider, including mechanisms for contract management, generic legal requirements and defined terms.

33 Online presentation of the Contract

The same arrangements for online presentation apply to the shorter-form Contract as to the full-length version, as set out below.

33.1 The General Conditions and Service Conditions of the Contract no longer need to be exchanged between the local parties as part of their local agreement. Rather, the GCs and SCs will apply to local contracts in their up-to-date online form, as published by NHS England from time to time. Under the wording set out on page 7 of the Particulars, they are incorporated into, and apply automatically as part of, each local contract by reference only. The only element of the Contract to be exchanged between the parties locally is the Particulars, which set out the locally agreed elements.

33.2 There is thus no longer any requirement for the previous process for National Variations, through which the parties to a contract would update it when directed by NHS England to do so to introduce changes made periodically by NHS England to the national provisions. Instead, any changes published by NHS England to the GCs and SCs will apply automatically from the date of publication (or whatever later implementation date may be specified in the wording of the relevant GC/SC). If a provider no longer wishes to provide services on the basis of the updated national terms, it will continue to have the option to terminate its contract, on notice, on a "no fault" basis under GC17.

33.3 The points below should be noted in relation to the arrangements for online presentation.

- The existing "order of precedence" within the Contract remains unchanged. As set out in GC1, the GCs take precedence over the SCs which in turn take precedence over the local content in the Particulars. So, it is not possible for local parties to set aside or depart from the national provisions of the GCs and SCs by seeking to agree alternative wording in the Particulars, and any attempt to do so will be invalid. The only exception to this is where the commissioners must add a local target to Schedule 4B (National Quality Requirements with Locally-agreed Thresholds) for specified metrics, where a different target has been agreed with NHS England as part of the annual planning round. This exception is given effect by the guidance notes at Annex A (National Quality Requirements) of the Service Conditions, and by SC3.1.1.

- NHS England will continue to consult formally on any proposed material changes to the Contract. No material changes will be made without input from stakeholders, and no changes will be introduced without prior notice. We envisage that the process for consultation and updating the Contract will remain annual, other than where there is an urgent need for an in-year change, as has been the case since 2013. There is no intention that the content of the Contract will become subject to rolling in-year updates.

- We will continue to publicise proposed changes in advance, on our website, through national bulletins and via email to our stakeholder list. The outcome of

every consultation will be confirmed in the same way, with updated Contract documentation published on the Contract webpages.

- There is no need for commissioners to send "notice letters" to providers, informing them of changes to the national terms. Commissioners may choose, if they wish, to contact relevant providers to alert them to specific changes in the national terms, but the onus will be on both commissioners and providers to keep themselves informed of the current terms.

- The current Particulars, GCs and SCs will always be published at https://www.england.nhs.uk/nhs-standard-contract/, but NHS England will also continue to publish previously applicable GCs and SCs, so that there is always an accurate, accessible record of which versions applied at which time.

- The Service Conditions continue to allow for "tailoring" of the applicability of Contract provisions using service categories (acute, mental health etc) to denote whether or not the clause applies to the contract in question. Contract clauses which are not relevant to a specific contract, because the provider does not provide the services to which those clauses apply, will simply be "read over" as not applicable. There is specific wording on page 9 of the Particulars making this clear ("Note that certain provisions of the Particulars and Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others"). See paragraph 34 below for further detail on Service Categories.

- Other aspects of "tailoring" (for example, where a provision applies only to a provider which is a Trust and not to other providers) are now dealt with through the actual Contract text, rather than through the "applicability" column in the SCs.

34 Service categories

Within the shorter-form Contract, there is much less tailoring of the applicability of the Service Conditions and Particulars through the use of service categories.

34.1 The service specifications (set out in Schedule 2A) describe the full detail of the services the provider is required to offer. The service categories, listed in the Particulars, are broad descriptions of different types of services; as set out above, their sole purpose in the contract is to determine whether or not certain provisions within the Particulars and, especially, the Service Conditions apply to a specific contract.

34.2 For this reason, the service categories are not an exhaustive list of all the possible types of service. Rather, the list reflects the way in which the content of contracts can be tailored to reflect the nature of the service being provided.

34.3 When completing the contract documentation, commissioners should tick as many of the service categories as are relevant to the specific contract. There is inevitably some imprecision with the categories; if in doubt, tick all of those that

could potentially apply. Contract clauses which are not relevant to a specific provider, because it does not provide the services to which those clauses apply, will simply be "read over" as not applicable. There is specific wording on page 9 of the Particulars making this clear ("Note that certain provisions of the Particulars and Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others").

34.4 A number of points should be noted in relation to the Community Services category.

- It is aimed at out-of-hospital services – which could be provided by NHS Trusts, independent and voluntary providers, GPs or optometrists.
- If a provider of community services also runs community hospitals with inpatient beds, and acute contractual provisions are relevant, then the commissioner may also wish to tick the Acute Services category.
- Where primary medical services (for example, GP out-of-hours services) are being commissioned under an NHS Standard Contract as part of a package of services, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 26.3 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).

34.5 The Contract continues to include a Service Category for patient transport services (PT). In this context, however, note our guidance (set out at paragraph 7.4 above) that, where a package of services being commissioned includes transport services within scope of CQC registration, the NHS Standard Contract must be used – but that a package of transport services outside the scope of registration should not be commissioned using the NHS Standard Contract.

35 Contracts for new services or with new providers

> The shorter-form Contract allows for Conditions Precedent to be recorded but does not make specific provision for Transitional Arrangements. These may be included in Schedule 2G (Other Local Agreements, Policies and Procedures).

35.1 Completion of the relevant schedules of the Particulars is obviously a requirement for all contracts – but agreement of a contract with either a new provider or for a new service is likely to mean a focus on certain aspects of the contract which are sometimes less critical where the contract is a renewal of an expiring contract with an existing provider for an existing service.

Conditions Precedent (Schedule 1A and GC4.1)

35.2 Conditions Precedent are things which the provider must do, and documents which it must provide, after contract signature, to establish to the satisfaction of the co-ordinating commissioner that it is ready and able to start providing the Services as required by the Contract. So, they are necessary pre-conditions to the start of

Services (and not, as is unfortunately sometimes assumed, a to-do list for later, once Services are already up and running). Those listed in Schedule 1A of the Standard Contract without square brackets will apply in all cases. Those in square brackets will apply in many, if not most, cases. Additional Conditions Precedent required by commissioners may relate to, for example, works to premises being completed, equipment being safely installed and operational, and/or appropriate staff being in post and fully inducted. These additional requirements will need to be agreed locally and will differ according to local circumstances.

35.3 While the commissioner will wish to have sight of documents referenced in Conditions Precedent (e.g. CQC registrations, the provider licence etc), the documents do not need to be included in the contract itself.

35.4 The general rule is that each Condition Precedent must be satisfied by the Expected Service Commencement Date. If any Conditions Precedent have not been satisfied by the stated Longstop Date (a date after the Expected Service Commencement Date, which allows for an acceptable amount of "slippage"), the co-ordinating commissioner may terminate the Contract.

35.5 There may be circumstances in which it is appropriate to fix a Longstop Date for satisfaction of certain Conditions Precedent as a date before the Expected Service Commencement Date – for example, if there are staged tests or gateways which the provider must pass in order to establish its readiness to deliver the Services. By fixing such an early Longstop Date, the co-ordinating commissioner is given the ability to terminate the Contract before the Expected Service Commencement Date has passed, once it becomes apparent that the Provider has not passed early tests and so is incapable of getting itself into a position to provide the Services. But this type of arrangement will be the exception, not the rule.

35.6 It is important to note that the Longstop Date is not a contractual means of allowing a contract to be signed with various contentious issues parked for resolution by a later date. Commissioners and the provider must make their own individual judgements about whether a contract contains an acceptable package which they are prepared to sign and be bound by. They may each be prepared to note that some non-material issues are not yet agreed at the point of signature (the content of lesser schedules, for instance), with the expectation that these will be incorporated into the contract at a later stage, once agreed, through a variation. But it is very unwise to sign a contract with material issues unresolved. Indeed, unless key elements, such as service specifications and financial terms, are agreed, there will be uncertainty as to whether a contract has been created at all.

35.7 Note that Schedule 1B may be used to set out details of any documents which the commissioners are to provide to the provider before the Expected Service Commencement Date. These may include, for example, records and other documents which are to be obtained from a previous provider of the services.

Transition Arrangements (Schedule 2H and GC4.4 – full-length Contract only)

35.8 The parties may set out in Schedule 2H actions which each must take (and/or, in the case of the commissioners, which they must ensure that the outgoing provider of the Services must take) in order to ensure continuity of service and to effect an

orderly transition of provision from the outgoing provider to the new provider, and/or from the old service model to the new. These might cover arrangements in relation to the transfer of staff (linking to GC5.14 (TUPE) (Schedule 8 in the shorter-form Contract)), the transfer of premises and equipment, transfer of care of Service Users, transfer of patient records, and so on. Clearly, there may be overlap between Schedule 1A and Schedule 2H, and it may be appropriate to specify completion of actions on the part of the provider under Transition Arrangements as a Condition Precedent, in order to ensure that the right to terminate the Contract applies if the provider fails to complete those actions. (If using the shorter-form Contract, transition arrangements may be set out in Schedule 2G (Other Local Agreements, Policies and Procedures) if required).

Contractual processes carried forward from previous contracts

35.9 Where an existing contract is about to expire and the commissioner is intending to enter a new contract with the same provider, questions arise about what happens to contractual processes unfinished during the previous contract (a Remedial Action Plan or an Activity Management Plan, for instance).

35.10 Commissioners can, of course, minimise the impact of this issue by entering into multi-year contracts, so that the contractual process automatically carries forward from one Contract Year to the next, until the contract expires.

35.11 However, at the end of a contract of any length, unless commissioners take appropriate action, the default position will be that contractual processes begun under that contract will not automatically be carried forward to a new contract.

35.12 This issue can be addressed by the inclusion of the Plan agreed under the expiring contract within a Service Development and Improvement Plan under the new contract. In this situation, a commissioner may wish to treat the agreement of that Service Development and Improvement Plan as a Condition Precedent for the purposes of the new contract (in other words, that agreement of the continuing application of the Plan is a pre-requisite of the new Contract). Where, under an expiring contract, a commissioner has reached the stage of withholding or retaining funding in respect of a provider failure (under GC9 for example), the commissioner may also seek to specify in the Service Development and Improvement Plan to be included in the new contract that withholding or retention of funding will continue under the new contract, until such point as the original failure is rectified.

Actions relating to services delivered under the contract which don't take place until the contract has expired (e.g. review and challenge of M12 data or application of the consequences of an Activity Management Plan regarding activity reported after contract expiry) can still take place in accordance with the terms of the expired Contract.

36 Service specifications

A specification for the services to be provided should always be included within the shorter-form Contract at Schedule 2A. There is no mandated format for a specification, but commissioners should ensure that each specification clearly sets out, as a minimum, the service to be provided, the population and geography to be covered, where the service is to be provided and other key requirements.

36.1 The service specifications are one of the most important parts of the contract, as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified.

36.2 Service specifications are recorded in Schedule 2A of the Particulars; a non-mandatory model template for local determination and population is provided there. The template is a streamlined one, enabling specifications in contracts to be less restrictive and input-driven where desired, with more scope for the provider to adapt and refine over time how services are best delivered to meet the commissioner's long-term objectives and desired outcomes.

36.3 The way in which service specifications are developed will vary according to local circumstances. It is the commissioner's responsibility to develop service specifications. However, the commissioner may, subject to procurement advice, wish to involve prospective providers in developing a specification. A high level of clinical engagement is essential, and it is good practice to involve service users in the development of specifications wherever possible.

36.4 The specification template is intended as a guide, and the sub-headings are intended to act as suggestions. It is possible to add additional sections to the specification, if required. Commissioners may retain this structure, they may add additional sections, or they may determine their own. Where a commissioner chooses to determine their own structure, the guidance below is still relevant.

36.5 Considerations in completing the streamlined template are set out below.

Service name	Use this as your shorthand description of this particular service or bundle of Services
Service specification number	Use this to give this particular specification a unique reference number
Population / geography to be served	Use this to define the population for whom the Service is to be provided and/or the geographical area which it is to cover
Service aims and desired outcomes	Use this to describe the overall aims of the Service and the outcomes you want it to achieve or to contribute towards. • Outcomes can be for the population served as a whole or for individuals accessing specific Services.

	• They can relate to specific improvements in health delivered through the health Services being provided, overall improvements in population health status or narrowing of inequalities in health between different sub-populations. • The NHS Outcomes Framework will be a useful point of reference. • Be sure to describe aims and outcomes which can be realistically achieved over the duration of the contract. If your contract has a one-year term, don't include outcomes which will take ten years to deliver. • Be clear whether you are expecting the provider to deliver specific outcomes which are fully within its own control – or to help make progress towards broader outcomes which will require action by multiple organisations to achieve.
Service description and location	Use this to describe, in an appropriate level of detail, the Service which is to be provided. A specification should not be a detailed operational policy for a service. It is important to cover, at least: • the nature of the Service to be provided (that is, a clinical description); and • the locations from which the Service is to be provided (or criteria for how accessible such locations must be for Service Users). Consider carefully what your specification says about the locations(s) from which services are to be delivered. • In terms of locations for service delivery, you should only list specific locations which you (and any other commissioners with whom you are collaborating under paragraph 13 above) have commissioned to meet the needs of your local population(s) and which you have satisfied yourself, through your usual assurance process, are suitable for the provision of high-quality and effective services. • In some cases, you may want to give the provider some flexibility – so that they can use any suitable locations within your ICB's geographical area (or accessible from it within X minutes by public transport). • Be clear in the specification whether the service, or any specific elements of it, may / must / may not / must not be provided on a physical "in person" basis or on a "remote" basis (by telephone or online). Beyond this, you may wish to consider: • specifying hours of operation and/or levels of service capacity; • what specific standards or guidance, relevant to the particular Service (and over and above those referenced in the General Conditions and Service Conditions), the provider must comply with or have regard to – noting that specific Quality Requirements which the provider is required to achieve and report to the commissioner against should be set out separately in Schedule 4 (Local and Locally-agreed Quality

	Requirements) and Schedule 6A (Reporting Requirements), cross-referencing the relevant service specification; • how the provider will tailor the services to individual Service Users' needs (adding service-specific detail to any general requirements on personalised care in Schedule 2M); and • how this Service fits into the wider care pathway for the Service Users affected – showing how it links to other services / providers and describing any referral / treatment protocols under SC29 (including any applicable clinical criteria / exclusions) and linking to transfer / discharge processes in Schedule 2J. Remember to strike the right balance between detail and flexibility. Try to ensure that the specification is precise enough so that the provider must seek the Commissioner's permission, through a Variation, to make really material changes (including as a minimum those which would trigger a requirement for public consultation, for instance) – but, otherwise, leaves adequate scope for the way the provider organises the services to evolve, so as best to deliver the desired aims and outcomes.

Other points about specifications

36.6 Commissioners should avoid replicating wording or clauses which appear in the General or Service Conditions or setting out requirements in a service specification which contradict the content of the General or Service Conditions, or re-state such content in slightly different language. Doing so will simply cause confusion and, potentially, disputes. (In the case of conflict or inconsistency, the Contract makes clear, at GC1.2, that General and Service Conditions will take precedence over the Particulars, including any detail within a service specification.) However, commissioners should ensure that, within their service specifications, they use correct contract terminology listed in the Definitions in the General Conditions (for example, 'Service User' rather than 'patient').

36.7 Where the provider is to play a part in local delivery of the Enhanced Health in Care Homes and/or Primary and Community Mental Health Services care models, in collaboration with local Primary Care Networks, the service specifications templates at Schedule 2Ai and/or ii should be included, as appropriate, and completed / supplemented locally as required.

36.8 Where the commissioning of services is the responsibility of NHS England (including where commissioning functions have been, or are in future, delegated by NHS England to ICBs), there will often be one national service specification for the particular service, which has been designed with clinical input and signed off at national level. For specialised services, for instance, the Contract mandates that national specifications must be used.

36.9 The Double Crewed Ambulance Vehicle Specification must be used by ICBs when commissioning regional ambulance services. Guidance on reducing unwarranted variation in the delivery of ambulance services is also published by NHS England at NHS England » Lord Carter's review into unwarranted variation in NHS ambulance trusts.

36.10 NHS England has also produced guidance on commissioning, contracting and core standards for non-emergency patient transport services (NEPTS); this is available here on FutureNHS. (See also paragraphs 7.4 and 34.5 above on the use of the NHS Standard Contract for the commissioning of NEPTS.) NHS England has also published NEPTS eligibility criteria, and ICBs and local partners should have regard to these criteria when commissioning NEPTS.

36.11 Clinical Service Accreditation is the national, patient-focused and professionally-led accreditation and quality improvement framework previously supported by the Healthcare Quality Improvement Partnership. CQC recognises a wide range of accreditation schemes in the acute and mental health sectors (see the list published by CQC); where a provider is accredited, that informs and in some cases reduces CQC inspection activity. Commissioners may wish to include, in service specifications, requirements on providers either that they are successfully accredited for a specific service from the outset or that they must achieve accreditation by a particular date.

36.12 A service specification included in a local contract may be supplemented by one or more specific Individual Placement Agreements (IPAs). Where, for instance, a Commissioner has commissioned a care home provider to provide NHS CHC packages of varying complexity, then an IPA can be used to record agreement to the placement of an individual and can describe the care package that individual is to receive and the price payable. The IPA should be exchanged between the parties and signed separately. NHS England publishes a model IPA which can be used for this purpose.

37 Commissioner Requested Services / Hard To Replace Providers

> The arrangements for CRS and Hard To Replace Providers in the shorter-form Contract are identical to those in the full-length version.

37.1 NHS Trusts have now been brought within scope of the NHS Provider Licence and the Commissioner Requested Services (CRS) regime, alongside NHS Foundation Trusts and non-NHS providers. We therefore deleted, in 2024/25, the Contract provisions relating to Essential Services. These applied to NHS Trusts only and created a contractual arrangement which was broadly equivalent to CRS – but this is now no longer required.

37.2 The Contract continues to refer in SC5 to the CRS regime, under which the provision of services can be protected where the continued availability of those services is regarded as essential.

37.3 National guidance sets out how services can potentially be designated as CRS where there is no alternative provider close enough, where removing them would increase health inequalities, or where removing them would make other related services unviable. The guidance sets out a detailed process for designation,

including a right of providers to appeal against the commissioner's assessment. Commissioners should submit any new designation decisions via england.crs@nhs.net.

37.4 The Contract requires both parties to comply with the respective obligations under CRS Guidance, but any potential regulatory interventions under the guidance would not come within the remit of the contractual arrangements between the parties. There is no requirement for decisions on CRS designation to be listed in their local contracts.

37.5 SC5 includes a requirement for providers to comply with their obligations under the Provider Licence in relation to NHS England's Hard To Replace Provider regime. Under this regime, NHS England may designate certain providers as "hard to replace" – on the basis that the provider's services are of sufficient scale or complexity nationally or regionally that NHS England considers that their unavailability – due to the provider's insolvency or quality issues – would impact on patients. The 'hard to replace' regime enables NHS England to apply the Continuity of Service licence conditions of a provider's licence, irrespective of whether any individual commissioner has chosen to designate that provider's services as CRS.

37.6 Under the Contract:

- any party proposing a Variation must have regard to the impact of the proposed Variation on other Services, in particular any CRS or on the designation of the provider as a Hard To Replace Provider (GC13); and

- the provider must ensure that, when Services are suspended or terminated, there is no interruption in the availability of CRS (GC16 and 18).

37.7 Commissioners should ensure that they make very clear their requirements in respect of designation of CRS in procurement documentation and in pre-contract discussions with providers.

38 Assignment, novation and sub-contracting

The provisions relating to assignment, novation and sub-contracting in the shorter-form Contract are very much shorter than those in the full-length version, and there is no expectation that sub-contractors will be recorded within a schedule to the Particulars. Our expectation is that sub-contracting of material elements of the services will typically not be a feature of the type of commissioning arrangements which are to be governed by the shorter-form Contract, and so more detailed provisions are not necessary. But the basic position remains that the provider may not assign, novate or sub-contract without the co-ordinating commissioner's prior written approval and that the provider remains liable to the commissioners for the acts and omissions of its sub-contractors.

38.1 We have shared the slides and recording from our webinar 'Sub-Contracting under the NHS Standard Contract' on our page on the FutureNHS platform, and this provides a useful introduction to many of the issues below.

38.2 GC12 governs assignment, novation and sub-contracting. There may be circumstances where the provider wants another party to take over as provider under the contract – for example, if the provider is a company and is selling its business and assets to another company. GC12 states that the provider cannot assign, novate or sub-contract any of its rights or obligations under the Contract without the prior written approval of the co-ordinating commissioner. (This situation may be contrasted with the sale of shares in a provider company, to which the Change in Control provisions at GC24 apply.) An assignment and a novation are slightly different things in legal terms. An assignment of a contract by a provider will not release that provider from its obligations under the contract. A novation, on the other hand, will effectively cancel the original contract and replace it with a new one between the commissioner(s) and the new provider. Either may have material implications under the NHS Provider Selection Regime. Either will need to be appropriately legally documented. If approached by a provider for consent to an assignment or novation, commissioners should, **before giving consent or even considering doing so**:

- ask the provider to give them as much information as possible about the proposed transaction, including the reason for it, the parties involved, and the experience and capability of the proposed new provider;
- explain to the provider that the commissioners will need to take legal advice on the request, any procurement implications, and any documentation related to the assignment or novation;
- require the provider to confirm that it will cover the commissioners' costs (including legal costs) in relation to the application for consent and all matters connected with it; and
- take legal advice, as above, and proceed in accordance with that advice.

38.3 We are aware that there can be confusion about the extent to which commissioners should be involved in decisions around sub-contracting, and guidance on this is therefore set out below.

38.4 The provider is wholly responsible to the commissioners for the delivery of the services and for the performance of the obligations on its part under the contract. The default assumption is that the provider will actually provide the services, and everything required in order to deliver those services in accordance with the contract, itself. However, in practice, most providers will wish to or need to sub-contract elements of the services, or contributions towards their delivery, to others.

38.5 What do we mean by a sub-contract? For the purposes of the Contract, a sub-contract is defined very broadly: it is any contract entered into by the provider or by any sub-contractor for the purpose of the performance of any of the provider's obligations under the contract. So that would include contracts entered into by the provider or by its sub-contractors with providers of clinical services (often known

as “provider-to-provider” contracts), clinical support services, goods and equipment on which the provider or the sub-contract relies in order to be able to deliver the services in accordance with the contract entered into with the commissioners.

38.6 It is important for both commissioners and providers to recognise that sub-contracting in no way relieves the provider from responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract: failure on the part of a sub-contractor does not excuse the provider from its obligations to the commissioners.

38.7 Nevertheless, commissioners will have an interest in sub-contracting arrangements. Depending on the scope and nature of the service or contribution being sub-contracted, they will need a greater or lesser degree of assurance as to the identity, level of competence and experience of the sub-contractor and the terms on which it is being appointed. Overall, the level of scrutiny which any sub-contract requires from the commissioner should be in proportion to its materiality, in terms of its potential impact on patient care. Commissioners will need to strike a careful balance, aiming for an appropriate and manageable level of oversight and not for micro-management of operational detail.

38.8 GC12.1 states that the provider is not to sub-contract any of its obligations under the contract without the written approval of the co-ordinating commissioner. **So, the co-ordinating commissioner is able to exercise control over what, how and to whom the provider sub-contracts the performance of those obligations**. The extent to which it does or should exercise that control in practice will, as suggested above, depend on the scope and nature of what is to be sub-contracted. It is important that commissioners and providers reach an understanding, in the context of their contract, as to when and how this control will be exercised. It may, for example, be readily agreed between the parties that the provider will be free to contract with suppliers of consumables and providers of support services such as catering and cleaning without seeking consent to each individual sub-contract: in effect a blanket consent is granted at the outset. On the other hand, who supplies particular consumables may, in the context of a particular commissioning contract, be very important to the commissioners, and they may therefore wish to exercise the right of approval over sub-contracts for those consumables. Providers should, however, always be mindful of the default position in the Contract, which is that sub-contracting without prior written approval is a breach of contract entitling the co-ordinating commissioner to terminate the contract if it chooses (see GC17.10.15).

38.9 GC12.4 allows the co-ordinating commissioner to designate a sub-contract as a Material Sub-Contract. “Material” in this context means that it relates to all or a significant and necessary element, or contribution towards, the delivery of a service. Materiality is not about the value of the sub-contract, or necessarily about whether or not the subject matter of the sub-contract is itself a clinical service; the key is the importance of the sub-contract and the sub-contractor to the delivery of the provider’s services. If a sub-contract is designated by the commissioner as a Material Sub-Contract, specific controls will apply, governing its termination, variation or replacement (see GC12.5).

38.10 It is important that the co-ordinating commissioner makes it clear to the provider, before awarding a contract:

- which (if any) proposed sub-contracts it considers to be Material Sub-Contracts (to be detailed in Schedule 5B);
- which (if any) Material Sub-Contracts must be in place, in a form approved by the co-ordinating commissioner, at the point of contract award;
- which (if any) Material Sub-Contracts must be in place, in a form approved by the co-ordinating commissioner, by the (relevant) Expected Service Commencement Date, as a pre-condition to the commencement of delivery of the Services (or the relevant Services) (to be detailed in Schedule 1A). (Note that it is possible to specify staggered Expected Service Commencement Dates for different Services, with conditions precedent attaching to each, if service commencement is to be phased.)

Form of sub-contract

38.11 It is for the provider to put the sub-contract in place, but the commissioner has the right to approve the terms of the sub-contract if it wishes. There is no mandated form of sub-contract (see paragraph 38.16 below), but the NHS Standard Contract places a number of specific requirements on the main provider in relation to the conditions of any sub-contracts (see, for example, GC21.14-16 of the full-length Contract – requirements relating to patient confidentiality and data protection).

38.12 The NHS Standard Contract itself is not designed for use, and should not be used, as a sub-contract. One simple, practical example of why this is the case relates to the NHS Payment Scheme. The Standard Contract requires the commissioner to pay the provider in accordance with the NHS Payment Scheme (meaning the principles and rules set out in the current NHS Payment Scheme guidance) – but no such requirement applies where a provider is paying a sub-contractor.

38.13 We have provided, at Appendix 3, some example scenarios illustrating which form of contract, sub-contract or other agreement should be used in different situations.

38.14 Where NHS providers are placing sub-contracts for goods and non-clinical services, they may appropriately use the standard NHS terms and conditions (queries on which may be directed to england.nhseCommercialGovernance@nhs.net). Where the sub-contract is of a clinical service, the national terms and conditions for goods and non-clinical services will not be suitable.

38.15 NHS England produces model sub-contracts for use by providers for clinical service sub-contracting, for use with the full-length NHS Standard Contract and with the shorter form Contract. These model sub-contracts, which we refer to as NHS Standard sub-contracts, provide a systematic means of flowing down the relevant provisions from the provider's contract to the sub-contractor. These model sub-contracts will be updated in due course to reflect the 2026/27 Contract and republished on the NHS Standard Contract 2026/27 webpage. Note that we publish a version of the model sub-contract under which multiple head providers

can place a single sub-contract with a chosen sub-contractor.

38.16 Use of the model sub-contract is not generally mandatory, although its use may be mandated by specific frameworks if appropriate, but its use will save providers time and offer greater assurance to commissioners that robust sub-contracting arrangements are in place.

38.17 Where a provider does not use the national model sub-contract, it should ensure that the sub-contract it does put in place reflects the relevant elements and requirements of the NHS Standard Contract.

38.18 We are aware of some confusion concerning sub-contracting arrangements where GP practices, operating through Primary Care Networks (PCNs), seek to sub-contract certain obligations under their primary medical care contracts to other providers such as Trusts. Use of the NHS Standard sub-contract is not appropriate in such cases; rather, NHS England has published a sub-contract for the provision of services related to the Network Contract Directed Enhanced Service, and this is the form of sub-contract which should be used (queries on its use can be directed to england.gpcontracts@nhs.net).

38.19 Many sub-contracting arrangements which providers propose, the reasons for them and their implications in terms of service delivery, indemnity arrangements and so forth, will be straightforward and will not raise serious concerns for commissioners. But others may be more complex, especially where they relate to a provider's complex organisational arrangements (around parent and subsidiary companies, for instance) or raise issues around VAT applicability. If approached by a provider for consent to a sub-contracting arrangement in a complex case of this kind, commissioners should, **before giving consent or even considering doing so**:

- ask the provider to give them as much information as possible about the proposed sub-contractor and sub-contract, including the reason for it, the parties involved, and the experience and capability of the proposed sub-contractor;
- explain to the provider that the commissioners may need to take legal advice on the request, and any documentation related to it;
- require the provider to confirm that it will cover the commissioners' costs (including legal costs) in relation to the application for consent and all matters connected with it; and
- consider taking legal advice and proceed in accordance with advice given.

Management of sub-contracts

38.20 Management of the sub-contractor is the responsibility of the provider. The provider is responsible to the commissioner for all of the services, including any provided by sub-contractors. However, the co-ordinating commissioner does have powers to require the replacement of sub-contractors in specific situations, as set out in GC12.13 (full-length Contract).

39 Quality of care

The core requirements on providers in relation to the provision of safe and effective care are the same under the shorter-form Contract as in the full-length version – but there are far fewer applicable national standards, less detail about specific national policy requirements and a greater reliance on the concept of "Good Practice" (as defined in the Contract). Contract management processes are generally abbreviated in the shorter form, but the provisions for service suspension or contract termination provide protection of commissioners in the event that a provider is providing unsafe or consistently low-quality services.

39.1 The National Quality Board defines high-quality care as care which is "safe, effective, providing a personalised experience, well-led, sustainable and equitable". In considering how quality is reflected in the contracting process, commissioners should take into account all of the dimensions of quality contained in this definition.

Using the Contract to manage quality of care – an overview

39.2 Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and hold it to account for the quality of care it (and any sub-contractors) delivers. The key elements of the Contract dealing with quality are summarised below.

- The Contract requires providers to run services in line with recognised good clinical and healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, the Fundamental Standards of Care regulations and the CQC "quality statements" (SC1).

- The Contract sets clear requirements in respect of clinical staffing levels by reference to National Quality Board guidance and NHE England Workforce Safeguards Guidance (GC5, definition of Staffing Guidance). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every twelve months; they must undertake quality impact assessments before making material changes to staffing levels; and they must implement a standard operating procedure for responding to day-to-day shortfalls in staff numbers.

- The Contract requires providers to adhere to national guidance on specific service areas, such as infection control (SC21), safeguarding (SC32), end of life care (SC34) and the duty of candour (SC35).

- The Contract sets specific National Quality Requirements which the provider must achieve (unless amended by agreement with NHS England, as described in paragraph 33.3 above) in Annex A of the Service Conditions, and some

additional Local and Locally-agreed Quality Requirements (Schedule 4). Other national standards to be complied with are stated elsewhere in the SCs – National Standards of Healthcare Cleanliness in SC17 and National Standards for Healthcare Food and Drink in SC19, for instance.

- In addition to these nationally mandated requirements, commissioners can describe appropriately detailed service requirements – whether in terms of outcomes, quality measures or inputs and processes – through locally designed service specifications (Schedule 2A).

- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit and clinical outcome review programmes (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and the response to patient safety incidents and Never Events (SC33).

- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys and Patient Safety Incidents, and implementing improvements as a result (SC3).

- Finally, the Contract provides processes through which commissioners can intervene to ensure that high-quality care is delivered – by requiring regular submission of monitoring information (SC28), agreeing Service Development and Improvement Plans (SC20), requiring Remedial Action Plans to address service deficiencies (GC9), and ultimately by suspending services temporarily (GC16) or terminating them permanently (GC17).

39.3 It is essential that commissioners use the tools within the Contract to set high standards for providers and to monitor service quality continually, alongside expenditure and activity levels – and that they maintain a constant and close dialogue with providers about any issues relating to service quality. National Quality Board guidance on System Quality Groups and on Quality Risk Response and Escalation in Integrated Care Systems sets out how the different organisations (commissioners, regulators, providers, others) can be brought together locally to review service quality – creating a joined-up approach which allows information about quality of care to be triangulated across different organisations.

39.4 Detailed guidance on reporting requirements and on the use of contract management processes is set out slightly later in this document. The remainder of this section focuses on specific quality aspects.

National Quality Requirements

- These are set out in Annex A of the Service Conditions. As a general principle, all providers are expected to achieve all of the National Quality Requirements which relate to the commissioned services. However, for 2026/27, to align with the Medium Term Planning Framework for 2026/27 to 2028/29, we require commissioners to add a local target (to Schedule 4B

National Quality Requirements with Locally-agreed Thresholds) for a small number of metrics where a different target has been agreed with NHS England as part of the annual planning round. The metrics affected are:

- Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral;
- Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test (DM01);
- Waits in A+E from arrival to discharge, admission or transfer (percentage waiting more than 12 hours):
- Category 2 (emergency) incidents – mean time taken for an appropriate response to arrive; and
- Handovers between ambulance and hospitals, A+E departments or Urgent Treatment Centres.

39.5 Links to the detailed definitions for all of the National Quality Requirements are provided within Annex A of the Service Conditions, and some of the definitions are set out in Appendix 2 of this Guidance.

Local Quality Requirements

39.6 Local Quality Requirements are to be included in Schedule 4A and are for local agreement. They should be clinically appropriate and realistically achievable. As a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. As referenced in paragraph 39.4, there are a small number of metrics (18 week RTT waits, DM01 diagnostic waits, 12-hour A+E waits, Category 2 Ambulance Response and Ambulance Handover) for which commissioners should add the target agreed with NHS England during the planning round to Schedule 4B (National Quality Requirements with Locally-agreed Thresholds) of the Particulars.

Where a local target has been agreed with NHS England for a National Quality Requirement, it will take precedence in the Contract over the national target as set out in SC3.1.1. However, commissioners and providers should always work towards achieving the national targets wherever possible.

39.7 Schedule 4A provides a simple template for documenting Local Quality Requirements. The headings used are explained in the table below.

Quality Requirement	What is the specific standard the provider must achieve?
Threshold	This means the numeric measure of success – better than the threshold is satisfactory, worse than it is not
Method of Measurement	This describes how the provider's performance is going to be measured – what is the data source, what are the definitions?
Period over which the Requirement is to be achieved	Does the provider have to achieve this standard at all times, with zero tolerance of breaches? Or is the standard to achieve a certain minimum (%) level of performance over a month, or quarter or year?

Applicable Service	Which Service(s) is this standard relevant to?
Applicable Service Specification (commissioner-added Local Quality Requirements only)	In which Service specification is this standard referred to?

39.8 It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value. Provisions are set out in SC28 to address this (see paragraph 43.6-7 below).

39.9 The Contract no longer makes provision for financial consequences to be applied where a provider breaches a Local Quality Requirement.

39.10 Commissioners should work closely with local Healthwatch representatives in the design and monitoring of Local Quality Requirements and in assessing the extent to which providers are implementing service improvements.

39.11 Note that the Getting It Right First Time programme publishes standards for a range of medical and surgical specialties; these will be a useful source of potential Local Quality Requirements.

39.12 For 2026/27, we are recommending that commissioners of Community Health services include a provider-level target in each contract for Community Health Services that supports their achievement of the system-level target set out in the Medium Term Planning Framework. The target should be set out as follows:

Local Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Applicable Service Specification
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	tbc	See CHS SitRep technical specification and reporting FAQs at: https://future.nhs.uk/CommunityHealthServices/view?objectID=97297925	Year	As appropriate

Patient Safety

39.13 Requirements relating to patient safety are set out in SC33. Requirements under the full-length version of the Contract are summarised below.

- From 1 April 2024, all providers must comply with the Patient Safety Incident Response Framework (PSIRF).

- As part of compliance with PSIRF, each provider must agree with its co-ordinating commissioner a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan, as described in detail in PSIRF. These must be published on the provider's website.

- Under PSIRF, each provider must

  - engage compassionately with affected patients, carers and staff following any patient safety incident;
  - respond in a proportionate way to such incidents, undertaking investigations where appropriate; and
  - ensure that improvements to services are implemented following responses to incidents.

- The Never Events Policy Framework remains in force, and providers must continue to comply with it.

- Providers must be able to report incidents via the Learn from patient safety events service and must provide information on incidents to the co-ordinating commissioner as agreed under Schedule 6A.

39.14 The shorter-form version of the Contract contains similar but briefer provisions.

Contract provisions relating to the primary / secondary care interface

39.15 The Contract has always contained requirements on secondary care providers relating to communication and engagement with primary care providers – but this has become more important than ever in recent years, both to improve the convenience of care for patients and to ensure the most efficient use of clinical time. The Contract provisions have therefore been gradually strengthened over recent years.

39.16 A summary of the Contract interface requirements, for clinicians and managers, was published in 2017. In brief, they cover

- referral, including the management of DNAs and onward (consultant-to-consultant) referrals (SC6, SC8 and SC29);

- communication with primary care on discharge from hospital and following clinic attendance (SC11);

- provision of medication following hospital admission or attendance, and use of shared care protocols (SC11);

- provision of fit notes to patients (SC11); and

- managing patient care and investigations and communicating with patients and dealing with their enquiries (SC12).

39.17 Implementation of these requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices. The Contract therefore includes a requirement for the provider and the co-ordinating commissioner to undertake, by 30 September of each Contract Year, an assessment of the effectiveness of their interface working arrangements, to discuss their findings with the relevant Local Medical Committees and to agree and implement an action plan to address any deficiencies.

39.18 The importance of ensuring that the Contract requirements in this area are fully implemented at local level was restated in 2024 in the Delivery plan for recovering access to primary care.

39.19 Further detail on some of the interface requirements is set out below.

Referral, management of DNAs and onward referral

39.20 The NHS Standard Contract is not a vehicle which can place direct requirements on individual primary care clinicians, but it does require ICBs to do all that they reasonably can to ensure that GP referrals are made in accordance with agreed protocols, specifications and Prior Approval Schemes and via the NHS e-Referral Service, with the necessary personal and clinical information provided in the format approved by the Professional Record Standards Body (see https://theprsb.org/standards/clinicalreferralinformation/).

39.21 The requirement in relation to DNAs is sometimes misunderstood. SC6.12 requires the provider to operate and publish a Local Access Policy, which will, amongst other things, describe how the provider will manage situations where a patient does not attend a booked appointment. The key additional requirement, as set out in the definition of Local Access Policy in the General Conditions, is that this is done "ensuring that any decisions to discharge patients after non-attendance are made by clinicians in the light of the circumstances of individual Service Users and avoiding blanket policies which require automatic discharge to the GP following a non-attendance". Where providers automatically discharge all patients who do not attend a clinic appointment back to their GP, this can create inconvenience and delays for patients and cause significant additional work for practices in simply re-referring many of the patients. The Contract therefore requires that a provider's Local Access Policy must not involve blanket administrative policies under which all DNAs are automatically discharged; rather, any decisions to discharge are to be made by providers on the basis of clinical advice about the individual patient's circumstances. Note that a model local access policy has been published by NHS England on the Future NHS website; providers should review their existing policies and ensure that they are consistent with this model version.

39.22 The provisions on onward referral in SC8 have the similar aim of avoiding duplication of effort. In summary, SC8 enables onward referral by a secondary care clinician where:

- the onward referral is directly related to the condition for which the original GP referral was made or which caused the emergency presentation (unless there is a specific local ICB policy in place requiring a specific approach for a

particular care pathway); or

- the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, SC8 does not permit a secondary care clinician to refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused the original GP referral or emergency presentation. In this situation, the Contract requires the clinician to refer back to the patient's GP. The Academy of Medical Royal Colleges has published Clinical Guidance: Onward Referral, which outlines clear principles for how to avoid unnecessary "doubling up" of referrals and help patients move more easily though the care system.

Discharge summaries, clinic letters and other communications to primary care

39.23 The Contract requirements have three aspects.

- **Timing.** Discharge summaries following inpatient / daycase care and A+E attendance must be issued to general practice within 24 hours; clinic letters must be issued within seven days. (Note that this standard is not expressed in Operational Days, but normal calendar days.)

- **Transmission.** Discharge summaries and clinic letters must be sent to general practice only by direct electronic transmission.

- **Structure.** To gain the full benefit from electronic transmission, discharge summaries and clinic letters must be constructed using coded data and standardised clinical headings, so that data can be automatically extracted into GP records. This must be done in accordance with the standards for structure and content set out by NHS England at https://standards.nhs.uk/.

39.24 Guidance is available to support providers in implementing electronic discharge summaries and clinic letters, and further details on the structured approach to sharing clinical information are set out in the Transfer of Care resource library. NHS England has published separate guidance on the NHS Standard Contract requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems. An Information Standard (DAPB4042: Transfer of Care – Acute Inpatient Discharge Standard) covers electronic transmission to GPs of hospital discharge summaries following acute inpatient care.

39.25 Commissioners must support providers in resolving any issues about GP preparedness (in terms of IT systems) to receive electronic transmissions (see SC11.8). Commissioners should also take a reasonable and proportionate approach in managing performance against the electronic transmission requirements. The policy direction is clearly to ensure electronic transmission to all GPs, but commissioners may wish to focus first on ensuring that providers can transmit electronically to GPs within their local catchment area.

39.26 Note the following points.

- A provider is not necessarily required to send a clinic letter to the GP after each individual clinic attendance – this will depend on the individual clinical circumstances, as set out in SC11.7.

- For discharges from care where the Service User has not been admitted to hospital or treated in A+E, there is no nationally mandated requirement for a discharge summary to be sent in all cases. Instead, SC11.6 allows an appropriate locally specified requirement, including content, format, method of delivery and timescale, to be agreed and set out in Schedule 2J (Transfer of and Discharge from Care Protocols).

- We do not envisage that discharge summaries would ever be required from Patient Transport Services, and the wording of SC11.6 (SC11.3 in the shorter-form Contract) reflects this.

- 111 Services are subject to a separate requirement to send electronic Post Event Messages, rather than discharge summaries (SC11.6A).

39.27 Apart from the above provisions for transfer of or discharge from care and clinic attendance, the Contract does not set out other nationally mandated requirements for communication from the provider to the GP whilst a Service User is receiving ongoing care at that provider. But where a commissioner wishes to set out other local requirements for communication to GPs during a pathway of care (as opposed to at discharge), this can be done by using Schedule 2G (Other Local Agreements, Policies and Procedures).

Medication on discharge and following clinic attendance

39.28 The Contract requires the parties to have regard to high-level national guidance on prescribing responsibilities. The Contract also contains specific provisions relating to supply of medication to patients on discharge from inpatient or daycase care and following outpatient clinic attendance. We are aware that there is different practice around the country in respect of both issues. To be clear, the purpose of the measures in the Contract is, in summary, to set minimum requirements which all providers must meet. These are:

- for discharge from inpatient or daycase care, a minimum of seven (calendar) days' supply; and

- following clinic attendance, sufficient supply for a patient's immediate needs, at least up to the point where the clinic letter has reached the GP and the GP can then prescribe on an ongoing basis.

In each case, the Contract wording deliberately sets these as minimum requirements; if local practice and protocols require supply for a longer period, this must be honoured unless alternative local arrangements are agreed. Note that there is a requirement for providers – when supplying medication to patients on discharge or in clinic or when recommending medications for GPs to supply – to have regard to guidance published by NHS England for GPs on conditions for

which over-the-counter items should not routinely be prescribed and items which should not be routinely prescribed.

39.29 These nationally mandated requirements only cover medication. Clearly, hospitals may also supply dressings or appliances, and requirements in relation to these may be specified locally within Schedule 2J (Transfer of and Discharge from Care Protocols).

40 Not Used

41 The Service Development and Improvement Plan (SDIP)

> The concept of a Service Development and Improvement Plan is not generally part of the shorter-form Contract. Under the shorter form, if the parties wish to record their agreement of a plan to address a specific service issue, they can include this in their local contract at Schedule 2G (Other Local Agreements, Policies and Procedures).

41.1 The Service Development and Improvement Plan (SDIP, Schedule 6C) allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.

41.2 SDIPs differ from Remedial Action Plans (RAPs) under GC9 (Contract Management). RAPs are put in place to rectify contractual breaches or performance failures, whereas an SDIP is generally about developing an aspect of the services beyond the currently agreed standard. (Note however that, where specific actions and consequences are set out in a RAP under a contract which is soon to expire, commissioners may opt to roll those requirements into an SDIP under the provider's new contract, to ensure that the matters agreed are not lost in the switch from one contract to the next). Once included in the Contract, commitments set out in SDIPs are contractually binding.

41.3 SDIPs are for local agreement between the parties. They should be underpinned by the NHS IMPACT approach to continuous improvement. SDIPs may be aimed at improving quality and outcomes, boosting productivity and efficiency, redesigning pathways and introducing innovative technologies.

41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6C at the point where the contract is signed or incorporated into the contract subsequently by a locally initiated Variation. Progress against the plan should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9).

41.5 For 2026/27, there are two specific areas in which we recommend that commissioners and relevant providers (acute trusts) should consider an SDIP.

Both SDIPs relate to the appropriate use of microbiology investigations and improving compliance with existing standards:

- UK Standard for Microbiology Investigations Syndromic 12 – this SDIP should set out the steps the provider will take to ensure full and ongoing compliance with the UK Standard for Microbiology Investigations Syndromic 12 by no later than 31 March 2027.

  SDIPs should focus on producing full compliance with the required performance against the key performance indicators relating to achieving collection to load times and to ensuring that adequate volumes of blood care are cultured as follows:

  (i) Fill volume of sample: blood culture bottles that meet the optimum fill volume of 8-10mL for adults.
  (ii) Number of sets of bottles per patient; two sets of blood culture bottles taken at the same time for adults (two aerobic and two anaerobic total).
  (iii) Time from collection to load: blood culture bottles loaded within 4 hours of sample collection for adults and children.
  (iv) Neonates: negative blood culture results reported within 36 hours of sample collection.
  (v) Blood culture pathway should be monitored and audited regularly, reported as a core part of the clinical leadership and trust governance.
  (vi) Improve regulation and accreditation, working to ensure a balanced end-end pathway focus on key processes inside and outside of the laboratory to ensure test results support the best outcomes for patients and appropriate use of antibiotics B0686-improving-the-blood-culture-pathway-executive-summary-v1-1.pdf.pdf

- C. difficile infection (CDI) ascertainment – this SDIP should set targets for each provider to achieve compliance with the national guidance requirements by 31 March 2027.

  We know that there is considerable variation across providers in the ascertainment of CDI. In a large UK study across 32 hospitals, there was no difference in the number of potential causes of hospital onset diarrhoea per patient comparing those tested for CDI versus those not tested for CDI (Cross-sectional study of the prevalence, causes and management of hospital-onset diarrhoea - PubMed).

  UK guidance sets out which patients with diarrhoea should have samples submitted and how these should be tested for CDI (UK Standards for Microbiology Investigations - Investigation of faecal specimens for Clostridioides difficile (B 10 - Investigation of faecal specimens for Clostridioides difficile).

  Improving / standardising the ascertainment of CDI will improve patient management, reduce infection transmission risk and make comparisons of reported CDI rates more meaningful. Providers of acute services should already be submitting quarterly data to UKHSA on stool sampling and CDI testing (Quarterly Mandatory Laboratory Returns).

Both of the following metrics are currently collected by UKHSA. NHS providers (i.e. each acute Trust) should provide:

(i) Total number of stool specimens examined; and
(ii) Total number of stool specimens tested for a diagnosis of C. difficile infection

These data will be used alongside mandatory reported CDI rates to compare the ascertainment of CDI by acute providers. SDIPs should set targets for each provider to achieve compliance with the national guidance requirements by 31 March 2027.

41.6 As in previous years, the intention of these recommended SDIPs is not to require significant additional investment from commissioners or providers; rather, it is to encourage joint management action to tackle these important priorities to the extent possible within available resources.

41.7 More generally, as described in paragraph 36.11, accreditation schemes can provide a good structure within which to take forward service improvement activity. CQC has published a list of accreditation schemes which it takes into account in its inspections of providers. Where a commissioner and a provider have agreed that the provider will work towards formal accreditation for a particular service, an SDIP can helpfully be used to set out clear actions and timescales to deliver this.

42 Managing activity and referrals

The shorter-form Contract includes a requirement to include an IAP for a contract with services paid for on an activity basis but does not include a 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.

Access to services

42.3 The Contract must function as a robust tool through which commissioners can secure access to the services which their population needs. At the same time, commissioners need to be able to use the Contract to prevent access to care or treatment which they deem to be unnecessary, ineffective or inefficient. This will enable commissioners to commission services in line with the NHS Right Care approach. In this context, it is useful to re-cap how the Contract governs access to services.

42.4 SC6 requires the provider

- to accept any clinically appropriate referral where a patient is exercising his / her legal right to choice of provider – even where the patient's Responsible Commissioner is not a party to the local contract; and

- to accept any emergency referral or presentation for treatment within the scope of the services a provider runs, again even where the patient's Responsible Commissioner is not a party to the local contract. (There is an important caveat here that the provider must be able to provide such emergency treatment safely – we recognise that, for instance, an intensive care unit with fixed bed capacity may not be able to accept transfers from outside its local network if all of its beds are full of very sick 'local' patients. But the general principle is that a provider of NHS-funded emergency services must be open to any emergency presentation, regardless of the identity of the patient's Responsible Commissioner.)

(Note that, for the legal right of choice to apply to a particular service, the provider must have been commissioned to provide that service by at least one ICB. And the provider can then offer the service to other ICBs only as commissioned, that is, on the basis specified in the provider's contract with the first ICB. See paragraph 25.8-12 above for further detail.)

42.5 SC29.3-4 deal with referral protocols and clinical thresholds for treatment and make clear that such documents may be included within service specifications or other aspects of the contract which are agreed between commissioner and provider – but that, in other circumstances, they may instead be notified by the commissioner to the provider as a Prior Approval Scheme (described more fully below).

42.6 It is worth explaining how these provisions are intended to operate.

- Where a service operates on a wholly fixed payment approach, then the basis on which patients are to access that service (that is, the clinical threshold for patients to be referred and receive care or treatment) is, effectively, a critical determinant of the price. So, for example, it is probably not realistic to expect an intermediate care service which is funded to deal with referrals for patients over 85 to start accepting referrals from over-75s and operate within the same fixed price. In such a situation, it is appropriate for the 'referral and treatment criteria' under which the service is to operate to be included within the service specification (or separately within Schedule 2G (Other Local Agreements, Policies and Procedures)). If either party wishes to change them, this can only be done by agreement using the Variation provisions at GC13. And discussion on a Variation may, of course, also involve varying the price for the service.

- But what about the situation where a service operates on an "activity x price" basis, with full or marginal prices? In this instance, the price is not dependent on a fixed or guaranteed level of activity. So, for instance, if the commissioner identifies that it wishes to restrict access to certain treatments when specific clinical criteria are met, it is reasonable for it to do so – so long as what it is requiring the provider to do remains consistent with Good Practice as defined in the Contract. In this situation, therefore, referral and treatment protocols are best kept separate from service specifications and treated instead as Prior Approval Schemes, which the commissioner can introduce or change through notification to the provider (SC29.17 onwards), but which do not require provider consent.

42.7 What happens if a provider starts to offer and charge for new services which the commissioner has not deliberately chosen to commission? The answer will depend in part on what is documented in the local contract. In summary:

- Where the local contract contains precise service specifications, the commissioner will in principle be able to argue that, by introducing a new service or treatment beyond the scope of what is described in the specifications, the provider has breached its duties under SC3. The commissioner may therefore be on strong ground in refusing to pay for the new service.

- By contrast, where the specifications in the contract are much looser, the provider will have a stronger argument that it is reasonable for its services to evolve gradually in line with good clinical practice.

Prior Approval Schemes

42.8 A Prior Approval Scheme will typically set out a commissioner policy for access to a certain service or treatment – a high-cost drug, for instance, or a treatment of perceived low clinical value. By setting out the clinical criteria or access thresholds in advance, the commissioner enables the provider to offer treatment to patients without needing to seek specific approval from the commissioner on an individual patient basis. In determining potential Prior Approval Schemes,

commissioners will wish to review the evidence base and consider the need for appropriate consultation.

42.9 The commissioner should notify the provider of any Prior Approval Schemes before the start of the contract year. Schemes can be amended and new Schemes introduced in-year with one month's notice. Where this happens, SC29.20 makes clear that the new or amended Scheme will apply to treatment which is offered after the date on which the new or amended Scheme comes into effect.

42.10 As described in SC29.19 (SC29.10 in the shorter-form version), if any Prior Approval Scheme seeks to impose an obligation on a provider that would operate contrary to patient choice legislation and guidance, that obligation will have no contractual force or effect.

42.11 Where the commissioner determines, prior approval may also operate on an individual patient basis, with the provider seeking approval for each individual case. The Contract sets out a requirement to include a response time standard for prior approval requests in the Particulars. The commissioner must respond to a request for approval for treatment within this Prior Approval Scheme Response Time Standard or will be deemed to have given approval under SC29.21. SC29.22 also makes it clear that prior approval arrangements must not place at risk achievement of quality or waiting times standards.

42.12 The Contract makes clear that commissioners must have regard to the burden which Prior Approval Schemes can create for providers (SC29.17). This is particularly important now that ICBs and local partner Trusts have legal duties, under the Health and Care Act 2022, to work together to deliver system financial balance. It will not be in the interests of an ICB to insist on the operation of a burdensome Prior Approval Scheme, adding to the costs of its local providers, unless it is confident that a net overall saving to the local NHS will result. It is therefore important that commissioners:

- ensure that they place the onus on the right part of the system – if an ICB does not wish to commission a particular procedure, it can appropriately inform its GPs of this and advise them not to refer patients for that procedure; in other cases, where the decision to offer a specific treatment would be made only by the hospital clinician after diagnosis, a Prior Approval Scheme operated by the hospital provider is likely to be necessary;

- reserve the more onerous prior approval request arrangements for a small number of high-cost treatments and complex scenarios (where the decision as to who should access treatment will require detailed information about patients' individual circumstances); and

- review the cost-effectiveness of their prior approval arrangements – if a labour-intensive Scheme requiring approval in advance is consistently resulting in every patient receiving approval for treatment, it should probably be converted into a commissioning policy of the kind described in paragraph 42.8 above.

42.13 Providers, particularly those which deal with many different commissioners, often raise with us the burden which is caused by having to operate multiple different Prior Approval Schemes, covering the same conditions or treatments, but featuring slightly different requirements for different individual ICBs. Clearly, it is ultimately for each ICB to determine its own commissioning policies, and the Contract must allow these policies to be given effect. However, SC29.17 states a requirement for those commissioners operating under a single contract with a provider to use reasonable endeavours to minimise the number of separate Schemes they operate. ICBs must therefore seek to collaborate across local patches to adopt consistent clinical thresholds and administrative processes in their Prior Approval Schemes as far as possible, thus lessening the number and variability of different Schemes which any individual provider has to deal with.

Evidence-Based Interventions Guidance

42.14 Evidence-based guidance on the use of specific healthcare interventions is published by the Academy of Medical Royal Colleges at https://ebi.aomrc.org.uk/.

42.15 The guidance (referred to in the Contract as Evidence-Based Interventions Guidance) is given contractual effect through provisions included at SC29.24-25, which require

- commissioners to use all reasonable endeavours to ensure that referrers (GPs and others) act in accordance with the Guidance; and
- providers to manage referrals and provide the Services in accordance with the Guidance.

ICBs should:

- review the comparative data held on the Foundry activity dashboard, which allows them to identify outliers by activity level for their population; and
- for those interventions where the data suggests that there may be a material level of non-compliance with the EBI Guidance:
  - remind their GPs of the specific guidance to take into account when considering referrals for those interventions; and
  - consider introducing a Prior Approval Scheme approach (see paragraphs 42.8-13 above) on a targeted basis, with funding withheld from any providers which carry out those interventions contrary to the terms of the Prior Approval Scheme.

Overall responsibilities for managing referrals and activity

42.16 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. Where possible, commissioners should work collaboratively together across a contract to manage activity, especially when using the activity management processes.

- 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 in 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.

NHS e-Referral Service

42.17 The Contract contains provisions in relation to use of the NHS e-Referral Service (e-RS) at SC6, summarised in the table below.

Any provider must hold a contract with an NHS commissioner (ICB or NHS England) for a service, in order to be able to list that service on e-RS at all.

Acute providers must

- publish their (relevant) services on e-RS;
- use all reasonable endeavours to ensure that sufficient slots are available to enable direct booking of appointments via e-RS; and
- ensure that they accept all referrals made through e-RS via the "appointment slot issues" route (that is, where a GP or patient is unable to book an appropriate slot, but still wishes to make the referral).

Mental health providers must use reasonable endeavours to publish their (relevant) services on e-RS and be in a position to accept GP referrals.

All providers using e-RS must ensure that their services are listed correctly within e-RS.

- Each Service to which the legal right to choice of provider applies, and each site from which that Service will be delivered, must be listed so as to be available to all Referrers in England.

- All other Services, and the sites from which those Services will be delivered, must be listed so as to be available only for referral of individuals whose Responsible Commissioner has specifically commissioned that service.

(Note that:

- a provider should of course only list sites which it is permitted to use for the delivery of services in accordance with its signed contract; and

- where a service is to be provided online or by telephone, it should be listed on e-RS as "located in" the area of the ICB which holds the contract for the service.

See paragraph 36.5 above and Appendix 4 for further detail.)

Commissioners must use all reasonable endeavours to ensure that all GP referrals:

- are made via e-RS; and

- contain accurate patient contact details and the clinical information required under agreed referral protocols.

42.18 It is essential that providers take a responsible approach when seeking to change the listing of their services on e-RS.

- Where a service is covered by a contract, that contract will normally specify a location or locations from which the service is to be delivered. Where that is the case, the provider is not entitled to, and must not, simply list additional locations on e-RS. If the provider wishes to add additional locations, it must approach:

    - its current commissioner to seek a variation to its existing contract (if the new locations are chiefly to be used for referrals from the commissioner which holds that contract); or

    - a new commissioner, with responsibility for patients in the area most obviously served by the new location, to seek a new contract (to cover the delivery of services in a completely different location, primarily to attract potential referrals from that new commissioner).

- If a provider wishes to provide additional services (beyond those specified in its contract) from an existing or new location, it must not simply list these on e-RS. As above, it must approach the relevant commissioner, requesting a contract variation / new contract as appropriate.

42.19 The provisions of SC6.8, which apply only to GP referrals into consultant-led elective acute services, deserve particular attention. Under these:

- a provider need not accept any GP referral into a consultant-led acute outpatient service unless it is made through e-RS; rather, the provider will be able to return any non-e-RS referral to the GP;

- the provider must implement a process under which, in every case, it notifies any non-acceptance of a non-e-RS referral to the patient's GP without delay (that is, in accordance with specific locally-agreed timescales, as described in the guidance at https://www.england.nhs.uk/digitaltechnology/nhs-e-referral-service/); and

- each commissioner must ensure that local GPs are made aware of this process.

Indicative Activity Plan

42.20 Prior to the start of the contract year, the parties must agree, where possible, an Indicative Activity Plan (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 by the Service Commencement Date, the commissioner will have the right to set an IAP on or after that date. An IAP cannot effectively be retrospective and should only deal with activity that it is to be carried out from the point that it is agreed or set. A commissioner can also seek to agree an IAP (or set one) with an NCA (but not LVA) 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, all of the Contract terms and conditions also apply to NCA). Similarly, an IAP can be set for a provider carrying out activity under an implied contract where a contract has not yet been signed. The Service Commencement Date for both NCA and unsigned contracts will be the date on which the first referral is accepted by the provider or the date that the parties moved from a signed contract into an implied contract. For multi-year contracts, an IAP could have been agreed that covers more than one contract year but where this has not happened, a new IAP for the new contract year should be agreed before 1 April and can be set on or after that date. It should also be noted that an IAP is effective when set by the commissioner in accordance with the contract and cannot be blocked by a provider refusing to sign a variation to include it in the 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. Any 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 should 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 national standards 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. A record of the decisions that underpin the construction of the IAP should be recorded in the IAP.

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, by agreeing or setting an Activity Management Plan (AMP), require a provider to plan its future activity in such a way as to align with the IAP, and if necessary reduce activity below the IAP for the remainder of the year. The Commissioner may apply financial consequences and withhold payment as set out in the AMP under SC36.1.

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, maintaining a waiting list and treating patients in line with the IAP rather than turning them away.

42.25 An IAP must be agreed or set for all contracts which include services paid for on an activity basis. Before setting an IAP, Commissioners must:

- Take reasonable steps to agree an IAP with a provider before setting one.
- 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 host commissioner of the qualifying contract.)
- Construct IAPs with regard to applicable provider waiting times targets set out in NHS Medium Term Planning Framework 2026/27 to 2028/29.
    - Commissioners must 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 the commissioner must have undertaken analysis of demand, capacity and the impact on waiting times.
- Appropriately plan for clinically urgent activity such as abortion care, Cancer treatment (including chemotherapy and radiotherapy) and 111 calls and

ensure that sufficient activity is commissioned to cover all clinically urgent activity.

- Consider the potential equalities and quality impacts of any IAP, including patient safety and patient experience, and ensure these are discussed with providers.

42.26 We have now mandated adherence to the above guidance in the new SC29.5B. Where providers feel that the mandated requirements have not been followed by commissioners, they may use the Escalation Process or the Dispute Resolution processes set out in GC14.

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 exhausted all opportunities to reach agreement with the commissioner, 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. If the provider does not meet this timescale then this escalation route will not be available to them.

- The commissioner must complete its section of the Escalation Form within 10 working days of receipt from the provider, and return the form to the provider. If the commissioner does not meet this timescale, the provider may escalate without including the commissioner's position.

- The provider must send the completed Escalation Form to england.activityescalation@nhs.net at NHS England within 25 working days of an IAP being set and notified to the provider 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, 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 NHS England, then the case will be referred to an independent panel arranged by NHS England. The panel will 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.

- 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 10 working days.

- Should the provider be dissatisfied with the outcome of the above process, the usual processes for Dispute Resolution set out at GC14 will still be available to them.

- While the provider is pursuing an escalation in relation to an IAP, the set IAP will remain in place for all purposes.

- In relation to any contractual relationship (i.e. one provider, one commissioner), a provider may only apply once in any contract year for escalation to NHS England on the setting of an IAP.

- A commissioner is contractually obliged to follow the outcome of the Escalation Process.

- Escalations which relate to general disagreement about the IAP rather than the specific points set out above will be unsuccessful and we would ask providers not to consume valuable resource by seeking to use the Escalation Process for this purpose.

42.27 From our experience of running the Escalation Process, we add the following notes on the above requirements:

- Attempts to agree may be conducted by correspondence rather than through face-to-face meetings but commissioners must ensure that they have sought to fully engage with providers and considered their responses before setting an IAP.

- It is for commissioners to carry out the analysis required to understand the needs of their population and the activity they need to commission to meet their system performance and financial targets. Commissioners are not obliged to share their full analysis with providers but should be able to explain to providers the steps they have taken and the conclusions they have reached, if requested.

- Commissioners do need to consider performance at a system level. Sometimes this may mean that the performance at a specific provider deteriorates slightly in order to redirect resources to other services with greater need. Providers should understand this and support commissioners in making these difficult decisions.

- Whilst IAPs are indicative and not binding, they will indicate the level of activity that a commissioner has determined is needed to deliver their system plans. Providers should co-operate with commissioners in attempting to deliver activity at these levels and raise issues with commissioners in a timely way if increasing demand is likely to put these plans under pressure.

- Commissioners and providers should work together to consider how best to minimise the equality and quality impacts of any IAP. It is for commissioners to decide the level of impact assessment required for any IAP but they should discuss their decision with providers and ensure that providers have had an opportunity to give their views on these impacts.

Activity Planning Assumptions

42.28 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.

42.29 Whether or not to set APAs is a matter for the commissioner. Where the commissioner wishes to use them, they should be notified to the provider before the start of the contract year. 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.

42.30 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.

42.31 APAs are likely to be used particularly for acute hospital services. To be effective, they should be measurable and evidence based. Potential APAs include, but are not limited to:

- first to follow up outpatient ratios;
- commissioned 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.

42.32 By contrast with an IAP, 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 (Activity Management Plans, 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

42.33 On receipt of an activity report which indicates variances against the thresholds set out in the IAP, any party may issue an Activity Query Notice (AQN). Either party may also issue an AQN in relation to either breaches of APA thresholds or unexpected or unusual patterns of referral and/or activity. An AQN may also be issued by any commissioner in relation to NCA (but not LVA) activity if an IAP or APAs have been agreed or set for an NCA provider (or if unusual patterns of referrals or activity occur), and the same process should be followed. A commissioner who is not the Co-ordinating Commissioner should copy any AQN to the Co-ordinating Commissioner and endeavour to discuss it with them.

42.34 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

42.35 A Joint Activity Review will be used to identify the reasons for variances in activity and may result in an Activity Management Plan (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. When setting an AMP, the commissioner should consider whether the variance is material and whether it is likely to continue. Where possible, commissioners should consult with other commissioners, especially the Co-ordinating Commissioner, (or the host commissioner of the qualifying contract for an NCA arrangement) before setting an AMP and all commissioners should seek to align any AMPs and consider the impact on provider management of waiting lists. A Joint Activity Review should always fully consider the reasons behind any increase in demand and, where applicable, the actions which commissioners can take to manage demand e.g. by referral management or pathway transformation should be included in any Activity Management Plan.

The AMP may include agreements on how activity or demand should be managed for the remainder of the contract period (the provisions of an AMP cannot continue

beyond the contract period except where they relate to financial consequences of activity not yet charged for). The plan must not in any way restrict patient choice of provider. 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 e.g. 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 been breached 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, for example,

- 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.

We have published a suggested AMP template in our proforma contract management forms and change in control notification document.

42.38 When setting an AMP, commissioners must:

- Follow the contractual process to agree an AMP with the provider before setting a plan.

- 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 host commissioner of the qualifying contract.)

- Consider demand, capacity, performance and activity across their system and the impact on system performance and affordability targets (as agreed within the annual planning discussions), if using an AMP to reduce activity.

- Not constrain clinically urgent activity such as abortion care, Cancer treatment (including chemotherapy and radiotherapy) and 111 calls and ensure providers of such care can 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.

- Consider the potential equalities and quality impacts of any AMP, including patient safety and patient experience, and ensure these are discussed with providers.

The guidance at 42.26 is also relevant when following an Activity Management process with the exception that an Activity Management process will require meetings to take place.

42.39 The table below gives some more detailed examples of the ways in which an AMP can be used to address a specific situation. These examples are illustrative only; the list is not intended to be exhaustive or to indicate that any of these items must be included in an AMP.

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. • Commissioner reviews process for offering patients choice of provider – i.e. to ensure that full range of options are discussed with patients. • Provider, at the request of the commissioner, increases waiting times to reduce the level of activity to align with the 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. • Commissioner notifies and implements a new / revised Prior Approval Scheme.
Activity exceeds IAP because of increase in follow-up ratio in a	• Commissioner undertakes to promote better use of existing shared care arrangements, so that more follow-up is arranged in primary care.

particular specialty (above APA)	• 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. • 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. • Potentially, provider starts to return clinically inappropriate referrals to GPs or redirect them to the triage service, rather than accepting them.

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.

42.40 We have now mandated adherence to the guidance in para 42.37 in a new SC29.5B. Where providers feel that the mandated requirements have not been followed by commissioners, they may follow the Escalation Process set out below or use the Dispute Resolution processes set out in GC14.

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 exhausted all opportunities to reach agreement with the commissioner, may escalate the issue as follows:

- 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 AMP being set and notified by the commissioner. If the provider does not meet this timescale then this escalation route will not be available to them.

- 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. If the commissioner does not meet this timescale, the provider may escalate without including the commissioner's position.

- The provider must send the completed combined Escalation Form to england.activityescalation@nhs.net at NHS England within 25 working days of an AMP 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, 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 an independent panel arranged by NHS England. The panel will 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.

    - 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 10 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 must continue to adhere to the AMP.

    - In relation to any contractual relationship (i.e. one provider, one commissioner) in any contract year, a provider may only apply once for escalation to NHS England on the setting of an AMP.

    - A commissioner is contractually obliged to follow the outcome of the Escalation Process.

    - Escalations which relate to general disagreement about the plan rather than the specific points above will be unsuccessful and we would ask providers not to consume valuable resource by raising them.

Financial consequences under SC29

42.41 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.

42.42 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. 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" i.e. in line with the IAP.

42.43 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).

42.44 Equally, a provider's response to an AQN may prompt the commissioner to contest payment under SC36.30 (see section 46), either on the basis 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).

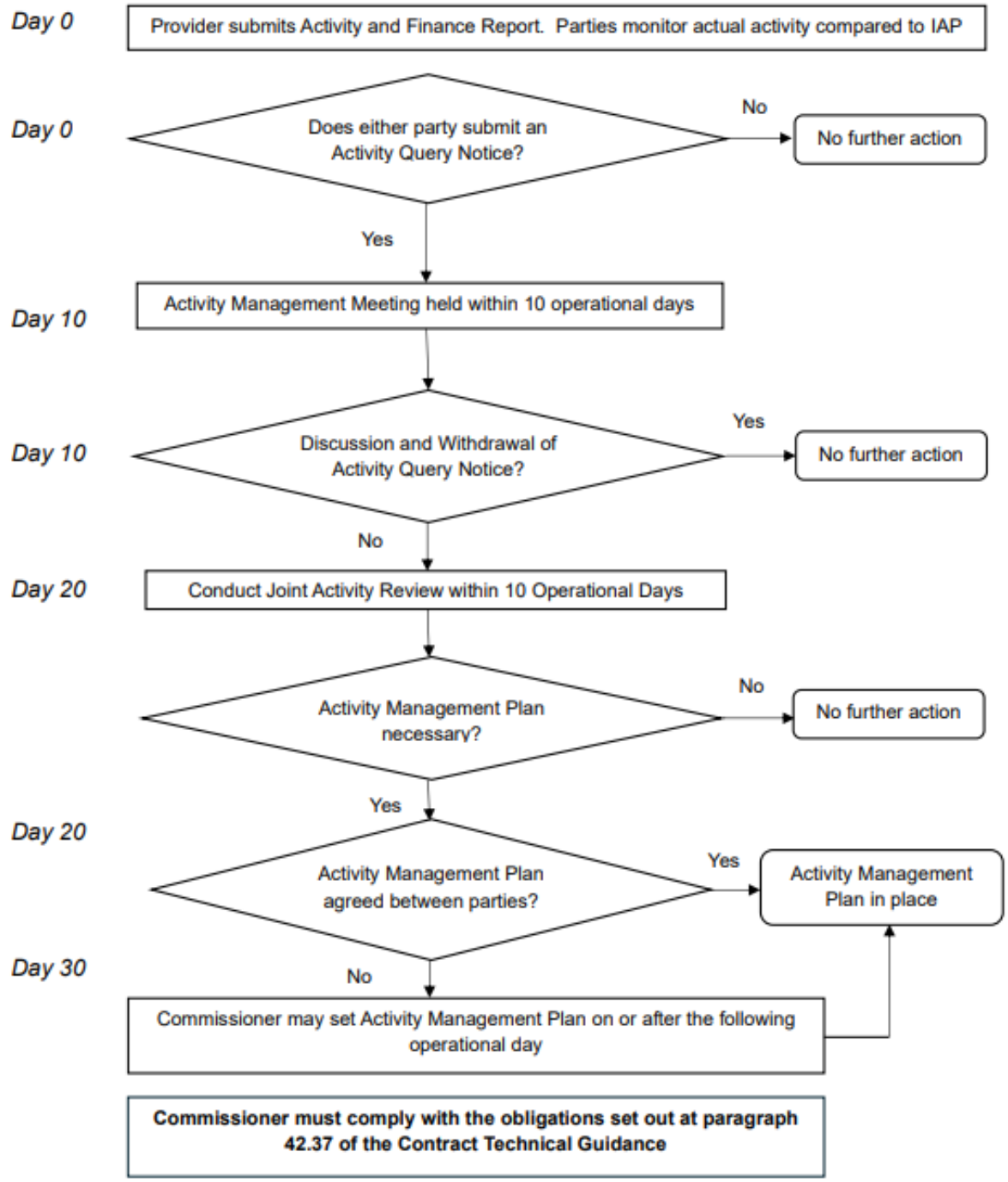
42.45 The only ways, however, in which a commissioner can properly withhold funding directly under SC29 are:

- to apply a financial consequence set out in an Activity Management Plan (SC29.16); or

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

The process diagram on the next page illustrates how an Activity Management Process might work. Timings are illustrative – the parties may meet earlier than timings given, an AQN can be issued at any point during the contract year and does not have to be issued immediately on receipt of data but should always be issued in a timely way.

SC29 – Managing Activity and Referrals



Yellow = updated from the 2025/26 versions of the Guidance published in April and September 2025
Grey = updated from the first version of the 2026/27 Guidance published in November 2025

43 Information, audit and reporting requirements

43.1 The Contract sets out a range of provisions relating to records and data, whether used for clinical or management purposes. Some of these are contained, for instance in SC23 (Service User Health Records), GC20 (Confidential Information of the Parties) and GC21 (Patient Confidentiality, Data Protection, Freedom of Information and Transparency).

43.2 The focus of this section of our guidance is on processes through which commissioners can access information about how the provider is providing services – under Schedule 6A (Reporting Requirements), SC28 (Information Requirements), and GC15 (Governance, Transaction Records and Audit).

Reporting Requirements

43.3 Good quality information is essential to enable providers and commissioners to monitor their performance under the contract. The following guiding principles should underpin the provision of information to support contract management:

- the provision of information should be used for the overall aim of high-quality service user care;
- it should be for a clearly communicated purpose or to answer a clearly articulated question, which may be required on a regular or occasional basis;
- the parties should recognise that some requests for information may require system improvements over a period of time;
- requests for information should be proportionate to the balance of resources allocated between clinical care and meeting commissioner requirements;
- unless there are justifiable reasons for doing so, which they can explain to providers, commissioners should not request information directly from providers where this information is available through national systems; and
- information provided should be of good quality.

43.4 Schedule 6A outlines the reports required under the Contract:

- **National requirements reported centrally.** This references the list of mandatory national-level data collections, approved by the Data Alliance Partnership Board. Providers must submit data returns as appropriate for their organisation type and the services they provide from the list. This also includes the delivery of any data or definition set out in relevant national guidance, and any Information Standards Notice (ISN) relevant to the service being provided.
- **National requirements reported locally.** This lists data and reporting requirements which are set nationally, but where the reporting is to commissioners locally.

- **Local requirements reported locally.** This is where any locally agreed requirements should be inserted. Commissioners should be clear why these reports are required and whether the information requirement is occasional or routine and should set the timeframe, content and method of delivery for these reports accordingly. Note the requirement to ensure that local datasets containing patient-identifiable data are submitted via the Data Landing Portal.

43.5 Schedule 6A provides a simple template for documenting local reporting requirements. The headings used are explained in the table below.

Local Reporting Requirement	What is the specific requirement here? A report covering what indicators for what Services?
Reporting Period	Is the report to be provided to cover a month, a quarter or a year?
Format of Report	How is the report to be presented? Written document or spreadsheet? How granular is the data to be – provider-wide, or broken down by site / locality / commissioner?
Timing and Method for delivery of Report	How soon is the report to be produced after the end of the period to which it refers? Is it to be sent to a particular person or presented to a particular meeting?

43.6 Despite the established principles above and the existing Contract wording which supports them in SC28, we receive consistent feedback about the high level of burden for providers which is generated by Local Reporting Requirements under the Contract.

43.7 A targeted approach with a limited number of well-chosen Local Reporting Requirements is likely to be the most effective approach. SC28.4 requires that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields. Particularly given the legal duties on ICBs and local partner Trusts, under the Health and Care Act 2022, to work together to deliver system financial balance, it is essential that commissioners are rigorous in reviewing the information burden they place on providers, ensuring that they only require information which they will use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route.

Failure to comply with SC28 and Reporting Requirements

43.8 From 2024/25 onwards, we removed the arrangements for “Information Breaches” from SC28. Breaches of information and reporting requirements should instead be handled under the overall GC9 process, which is already used for managing all other unrectified breaches – see paragraph 45 below.

SUS

43.9 SC28.17 mandates submission of datasets by providers to the Secondary Uses Service (SUS), where required under national guidance.

Data Quality Improvement Plans

43.10 Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to meet the requirements of Schedule 6A and to support both the commissioning and contract management processes. Although completion of a DQIP is not usually mandatory for each contract, we nonetheless encourage commissioners to use DQIPs routinely to address data quality issues highlighted through direct reporting at point of submission or through the Data Quality Maturity Index (DQMI). Additionally, for 2026/27, we are requiring the following DQIP to be employed where appropriate:

- As timely, high quality data for NHS services is a critical focus of the 10 Year Health Plan, we have introduced to the Contract at SC28.18 a requirement to reduce variance between first and final reconciliation date to 5% for both activity recorded and activity which is ungrouped (i.e. HRG= UZ01Z). As this is a new target, in 2026/27, Commissioners must assess whether their providers are achieving this target and, if they are not, must agree a DQIP on reducing variability between the data published by providers at first (flex) and final (freeze) reconciliation dates to the target level by the end of 2026/27. Commissioners are encouraged to review the current variation between flex and freeze data at their providers, benchmark this with other providers, and to agree a plan with their providers for the reduction of variation. Commissioners and providers should then draft a DQIP for inclusion in their contract, setting out the steps that providers will take to improve the timely publication of accurate data on their activity and meet the requirement at SC28.18.

- 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 NHS Futures in the Commissioning Data Sets – Data Quality Dashboards 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.

43.11 Note that SC28 includes a specific requirement for the provider to use all reasonable endeavours to optimise its performance under the DQMI, where applicable, demonstrating its progress through implementation of a DQIP or other appropriate mean. The DQMI currently covers the national datasets for admitted patient care, A+E, community services, diagnostic imaging, IAPT, mental health, maternity and outpatients.

43.12 Commissioners will need to differentiate between situations where a provider's data quality is acceptable overall, but with some improvements needed (in which case a DQIP will be appropriate) and those where data quality is unacceptable (which need to be managed formally using the provisions in GC9). Putting in place a DQIP means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under GC9 only if the requirements of the DQIP are not achieved.

43.13 Multiple DQIPs can be included within the same contract. DQIPs should be included in Schedule 6B at the point where the contract is signed or incorporated into the contract subsequently by a locally initiated Variation. Once included in the Contract, however, commitments set out in DQIPs are contractually binding. Progress against the DQIP should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9). In a multi-year contract, DQIPs should be updated periodically, as initial issues relating to data quality are resolved and new ones are identified.

43.14 In terms of coverage, DQIPs should provide quantified assurance that action is being taken in each of the following areas:

- Coverage – that where a data set exists and is relevant to a provider it is completed for all relevant services;
- Consistency – that is, where a data set is produced, the volume of submitted records is consistent over a timeseries;
- Completeness – that is, where a data set is produced, all relevant items hold expected values;
- Validity – that all data conforms to recognised national standards. Codes must map to national values and wherever possible, computer systems should be programmed to only accept valid entries;
- Defaults – the level to which default values specified in applicable information standards have not been used in excessively within the data collected;
- Timeliness – that all data is recorded to a deadline in line with the national reporting, and extract and refresh deadlines;
- Cleansing – covering duplication (that all necessary processes are in place to remove duplicated records), merging (that steps are being taken to ensure that separate records are not merged inappropriately) and auditing (that clinical coding checks are undertaken on a regular basis).

43.15 Commissioners are encouraged to use a range of evidence sources to inform what should be included in a DQIP as well as to identify and quantify the progress they need to make through DQIPs, including in particular the DQMI. Other possible sources are set out below.

- The monthly SUS data quality dashboard provides benchmarked evidence that commissioners should use to drive improvements in quantitative and process-

based data quality indicators for admitted patient care, outpatients and Emergency Care data sets as well as for maternity and critical care. Each of the SUS Commissioning Data Sets are covered by the DQMI.

- Other data quality reports are published relating to national data collections including the Mental Health Services Data Set, the IAPT Data Set, Community Services Data Set and Diagnostic Imaging Data Set. Each of these data sets is also covered by the DQMI.

- GC21.6 requires each provider to undertake audits of its performance against the Data Security and Protection Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality.

- The DQMI is used across a number of different frameworks, including the Single Oversight Framework within the Digital, Data and Technology Dashboard of the Model Hospital and is collected by the Care Quality Commission as part of their Well-Led Domain. To ensure consistency across each of these and to assist in setting thresholds for the DQMI within DQIPs, guidance is published on the Data Quality web page.

43.16 DQIPs may be particularly useful where new national reporting requirements or datasets have been introduced and where providers are not yet routinely complying with these. Commissioners should therefore ensure that they monitor closely the data submitted by providers of the relevant services and consider whether use of one of the available contractual levers (DQIP or GC9) would be appropriate to ensure that any problems with the quality of data submitted by individual providers are swiftly rectified.

Audit

43.17 GC15 covers Governance, Transaction Records and Audit and makes clear:

- the provider's responsibilities for carrying out a programme of audit at its own expense (GC15.7 in the full-length Contract, GC15.5 in the shorter-form); and

- the right of the commissioner to appoint independent auditors (who must be appropriately qualified) to review any aspect of the Services, the provider's invoices and/or the performance of any of the provider's obligations (GC15.8 in the full-length Contract, GC15.6 in the shorter-form).

43.18 From 2024/25, we removed from the full-length Contract the detailed provisions which previously governed how the financial implications of audit findings were to be managed. Both the full length and the shorter-form versions of the Contract now feature a much simpler and less transactional approach.

43.19 Note the following points in relation to independent audits under GC15.

- The co-ordinating commissioner must give the provider at least ten Operational Days' notice of its intention to appoint an independent auditor.

- Where an audit under GC15 identifies any breach by the provider of a contractual obligation, this can be managed under the contract management provisions in GC9. In this situation, once the final audit report has been received identifying such a breach, the immediate next step should be agreement and implementation of a Remedial Action Plan. There should generally be no need for the parties to follow the earlier stages of the GC9 process (Contract Performance Notice, Contract Management Meeting, Joint Investigation), because those stages have in effect already been covered under the GC15 audit process.

- In other situations, the appropriate response to the findings of an independent audit may be the agreement of a Service Development and Improvement Plan (see paragraph 41 above) or a Data Quality Improvement Plan (see paragraph 43.10-16 above).

- Independent audits under GC15 are for the commissioner to fund. However, where an independent audit identifies a contractual breach of an obligation by the provider, it is open to the commissioner to apply the provisions of GC11 (Liability and Indemnity) to recover costs which it has incurred as a consequence of the breach identified – see paragraph 47.32 onwards below for further information.

- Regarding the relationship between independent audits and information governance requirements in relation to personal confidential data, this issue may obviously arise in the case of audits focusing on clinical services. Providers need a legal basis for disclosing personal confidential data. Without this they are entitled, and indeed required, not to disclose such information, and GC15 therefore makes clear that access to such data must be "subject to compliance with Data Protection legislation (including any applicable Service User consent requirements)".

43.20 Note that the provider is under a more general obligation (SC2.1.4 in the full-length Contract, SC2.1.2 in the shorter-form) to "consider and respond to the recommendations arising from any audit".

- This includes audits not arranged under GC15 but carried out by third parties such as Royal Colleges.

- It also includes any audits which, by agreement (and subject to appropriate information governance arrangements), are carried out by members of the commissioner's or the provider's own staff; remember again that such audits are not independent audits under GC15.

44 Counting and coding changes

As the **shorter form Contract** is not used for acute services, in which activity recording issues tend to be more contentious, it does not include specific provisions for the management of counting and coding changes.

44.1 SC28 sets out how changes in the counting and coding of activity should be managed. In the past, this has often been a complex and contentious area, but – encouragingly – recently very few disputes have been brought to our attention. So we have retained the counting and coding provisions in the Contract but we are making clear that – in certain situations – it is open to commissioners and providers to implement them in a light-touch way. This applies where:

- an ICB is commissioning services from a partner Trust in the same local system (given that the ICB and the Trust are now under a legal duty to work together to deliver system financial balance, local disagreements about the financial impact of counting and coding changes should simply not be allowed to arise); and

- an ICB is commissioning services from a provider on an Aligned Payment and Incentive (API) basis, as set out in the NHS Payment Scheme (most counting and coding disputes have tended to be in relation to "coding drift" in non-elective services – but API involves fixed payment for non-elective care, so this issue should no longer arise).

In these situations, the parties must continue to follow the principles of SC28. It is important that the commissioner is always made aware of material changes in how the provider is recording activity, as there can be no shared basis for planning and monitoring without this. There should be no unplanned financial impacts from counting and coding changes. Within that, however, the parties can adopt – for example – a more flexible local approach to the deadlines and process set out in SC28 for notifying changes and neutralising their financial impact.

44.2 SC28 distinguishes explicitly between

- counting and coding changes made in order to comply with specific new national coding guidance (which we refer to below as "nationally-mandated changes" and which are now covered in SC28.8-28.9); and

- changes proposed in order to comply with existing previously published national coding guidance which is already in effect ("locally-proposed changes", covered in SC28.11-28.14).

NHS Digital merged with NHS England on 1 February 2023. Prior to that date, the "national coding guidance" described above will have been published by NHS Digital; from that date onwards, it will be published by NHS England.

44.3 The requirement to neutralise, in the short term, the financial impact of counting and coding changes applies to both categories. But there is a distinction between

the two categories in terms of the requirements around giving notice of proposed changes.

- The party putting forward a locally proposed change must do so by 30 September, for implementation on the following 1 April; whereas

- there is no requirement for the provider to give advance notice of a nationally-mandated change; all new guidance requiring such a change will be published on a publicly-accessible website, allowing commissioners direct access to the details and removing the necessity for notice. However, the provider must inform the commissioner when it commences implementation of new guidance.

44.4 SC28 makes clear that, ultimately, the need for, and extent of, any "neutralising" financial adjustment is triggered by the actual financial impact, in practice, of a counting and coding change, rather than solely by the impact which is estimated in advance, before the change is implemented. (This is made clear in SC28.9 and SC28.14.)

44.5 Local disputes over transactional issues such as these must be kept to a minimum, so that commissioners and providers can focus their efforts on more important matters relating to patient care. SC28.15 therefore requires the parties to work jointly and in good faith to monitor the actual impact of counting and coding changes and to agree the extent of any necessary financial adjustments.

Rationale for the national policy on counting and coding changes

44.6 For clarity, we have set out below the rationale for why the Contract must continue to contain requirements for the short-term neutralisation of the financial impact of counting and coding changes.

44.7 The NHS Payment Scheme guidance does not itself set rules for how patient activity is to be recorded – these are contained in the NHS Data Dictionary. Rather, the NHSPS guidance sets the basis on which recorded activity is to be grouped into different categories (e.g. healthcare resource groups (HRGs) for inpatient spells) and the prices which are to apply to those categories.

44.8 The national prices in the NHSPS (and under the National Tariff Payment Scheme and Payment by Results before that) have always been based on historic actual reference costs submitted by providers. So national prices are a product of:

- the historic actual costs of providing specific forms of patient activity; and

- the way in which providers have, historically, actually recorded that patient activity.

44.9 When each new national payment scheme is designed, the impact of changes to that design – such as the new grouping structure of HRG4+ for the 2017-19 iteration – is carefully modelled at national level, alongside other important factors such as inflation uplifts and efficiency requirements. This informs the eventual national prices, which aim to strike a reasonable balance between commissioners and providers.

44.10 For any national payment scheme to achieve its intended financial impact, it is fundamental that patient activity continues to be recorded on broadly the same basis that informed the calculations underpinning the scheme's development. Changes in recording practice could, under an activity-based payment system, have destabilising financial effects. For this reason, there have always been provisions in national guidance for managing changes in recording practice. These provisions were originally included in the PbR Code of Conduct and then, when that was discontinued in 2013, transferred into SC28 of the NHS Standard Contract.

44.11 The Contract provisions aim to strike a reasonable balance between

- on the one hand, promoting, in the medium term, accurate recording of activity in line with national data definitions, with providers being rewarded on the basis of accurately recorded activity data; and

- on the other, offering protection in the short-term, for commissioners and providers, against the financial impact of changes in the way activity is recorded.

44.12 We believe that it is essential that the short-term financial protection provided by the Contract provisions applies both to locally-proposed and to nationally-mandated changes, because neither can have been built into the national calculations for the setting of NHS Payment Scheme unit prices described in paragraphs 44.6-44.9 above.

What do we mean by a counting and coding change?

44.13 The SC28 provisions relate to the counting and coding (that is, recording) of activity (that is, how Service Users are cared for or treated clinically under the contract).

44.14 In that context, a change in counting and coding practice is:

- a change from a previous, historically established way of recording activity which affects or would affect how or whether that activity is visible (i.e. reported) to the commissioner, through submission of datasets through SUS or other local reporting routes;

- a change which is systematic, in that it affects a group of patients in a similar way or ways, rather than just affecting an individual patient; and

- a change which may affect whether a certain activity is recorded at all or how it is recorded, in terms of how it is classified (as inpatient, outpatient etc.) and/or the extent of any detailed clinical coding of diagnoses and procedures.

44.15 There are two key points to bring out from the first element of this.

Is this a change from historically established practice?

44.16 Realistically, we know that activity recording practice is not static. A provider may record a particular activity on basis A for five years, then a key member of staff may leave and his or her replacement may, in error, start recording on basis B. This may go on for, say, three months before the provider or commissioner spots the change. Clearly, the historically established practice here is basis A. So the provider has been at fault in making the change to basis B (firstly because it has not given prior notice and secondly because basis B is technically incorrect), but there is no question of it having to give notice in order to revert to basis A.

44.17 Not all cases will be so clear-cut, of course. A good rule-of-thumb is that a particular activity recording practice should be considered 'historically established' to the extent that it has informed the Expected Annual Contract Value for the current Contract Year.

Is this a change in what is or would be visible to the commissioner?

44.18 What matters is what the commissioner has been and will be able to see about a particular activity. If there is a change in this, then that is a counting and coding change.

44.19 Some cases will be very straightforward – a provider may start recording a certain group of cases as daycases, rather than outpatient procedures, say. This will immediately flow through to SUS in a way that is visible to the commissioner – so it will be a counting and coding change.

44.20 But take a different example. A provider has always recorded data about a particular clinic on its own PAS but has never charged for the activity. It realises that there is a national price for that service which it has not been applying and starts to apply it. Is this a counting and coding change? It depends:

- If the provider has historically submitted the relevant datasets to SUS (or to the commissioner / CSU via another local route), then the commissioner has always been able to see the activity data for the clinic. All that has changed is that the provider has started to apply the national price. This is **not** a counting and coding change, and the provider may therefore start to charge for the clinic prospectively as soon as it is able.

- But if the provider has never submitted the relevant datasets for the clinic, but starts to do so for the first time as backing data for the charges it is wishing to make, then that is a change in what the commissioner can see about the service – so it is a counting and coding change, the provider cannot start to charge immediately, and the provisions of SC28 must be followed.

44.21 The following are therefore not counting and coding changes.

Changes in service provision

44.22 A change solely in the way in which services are provided may have a knock-on effect on the type, volume or casemix (and therefore cost) of activity recorded (because Service Users are now experiencing a different service). For a service change of this kind to proceed, it is likely that agreement of a locally-initiated Variation under GC13 will be required, but a service change such as this does not fall within the provisions of SC28 on counting and coding changes.

Changes in charging

44.23 A change solely in the way in which activity is charged for, where there is no change in the way in which that activity is recorded and made visible to the commissioner (as described in the first bullet point of 44.20 above, for instance), is not a counting and coding change.

44.24 It is worth saying a little more about the interplay between the counting and coding provisions in SC28 and the NHSPS.

- Clearly, the provisions of SC28 are not intended to prevent or delay the adoption of new prices, currencies and rules mandated through the NHSPS. Providers and commissioners do not need to give each other notice under SC28 of the application of new NHSPS arrangements, and the impact of the new NHSPS is not subject to the provisions in SC28 for financial neutrality.

- Applying new NHSPS arrangements without changing the way in which activity is recorded is one thing; making changes to how activity is recorded in order to increase, or with the effect of increasing, income under those new NHSPS arrangements is another. The latter definitely does fall within the scope of the counting and coding provisions at SC28.

- The two examples below explain this further.

    - A national change such as the introduction of HRG4+ and the associated payment grouper does not, per se, fall within the requirement for financial neutralisation at SC28. HRG4+ is not about how patient activity is recorded in terms of activity classification and diagnostic and procedure codes; it is about how recorded activity is grouped and then charged for. The crucial difference is that the financial impact of HRG4+ has been allowed for, to the extent possible, as part of commissioner allocations and NHSPS setting – there is therefore no need for local adjustments to neutralise its impact.

    - By contrast, if a provider makes a change to its historically-established approach to the counting and coding of activity, in order to benefit financially from a change to the national structure of the payment scheme such as HRG4+, then that does qualify as a counting and coding change under SC28.

- Best Practice Tariffs are worth particular mention here. The whole intention of the national BPT approach is to give providers an incentive to adopt proven new approaches to service delivery. So, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a locally-initiated Variation to be agreed in respect of any change of service provision necessary to achieve this, and the implementation of the BPT would not fall with the prior notification requirements for counting and coding changes under SC28 – because the BPT is about service delivery, not activity recording. (The one exception to this is where a provider intends to achieve compliance with a BPT simply by changing how it records activity.)

Notifying and implementing locally proposed counting and coding changes

44.25 Providers must notify any locally proposed changes which they intend to make to their recording practice to their commissioners six months in advance. Equally, if commissioners wish to propose local changes in how a provider records activity, they must give that provider six months' notice.

44.26 The Contract does not set explicit requirements for the form which notifications of proposed changes should take, but they must be made be in writing and delivered in accordance with the notice provisions set out in GC36.

44.27 The issue of whether notice has been properly given can cause disputes, and so we have sought to clarify the requirements below.

- The notice must describe the nature of the change proposed (that is, what actual change is proposed relative to the provider's current practice) and the rationale for it (that is, why it is technically correct under NHS Data Dictionary definitions and national guidance on clinical coding). A notice letter which simply states a broad intention to improve recording or coding, without any specific detail, would not be valid; there must be a concrete actual proposal.

- As a matter of good practice, notice should contain the best available estimate of the impact on the type and mix of activity recorded and of the impact, at current prices, on payments between the parties. However, it is not always possible to quantify in advance – either accurately or at all – the financial impact of a particular proposed counting and coding change. Failure to quantify, when giving notice, the expected financial impact of a proposed change does not render that notice invalid.

44.28 The expectation in the Contract is that any locally proposed changes agreed will be implemented:

- (for multi-year contracts not in their final year) at the start of the Contract Year following the Contract Year in which notification is given;

- (for single-year contracts or expiring multi-year contracts), from the start of the contract covering the year following the one in which notification is given (assuming of course that such a contract is awarded to the same provider).

44.29 As a general rule, notice of locally proposed changes must therefore be given no later than 30 September in any year, with the changes to be implemented on the following 1 April. However, the parties may instead agree a different implementation date.

44.30 Changes proposed by either party should be discussed and agreement reached on whether they are consistent with national recording guidance and should be implemented.

44.31 Where agreement cannot be reached on whether a change should be implemented, the parties may refer the matter for dispute resolution.

44.32 Any locally proposed changes which are notified after 30 September 2024 will be too late for implementation from 1 April 2025 (unless the party not proposing the change agrees that it can go ahead then). They should instead be re-submitted for the following year (that is, by 30 September 2025), with a consequent delay in potential implementation, if agreed, and full financial impact.

Nationally mandated counting and coding changes

44.33 Information about formal changes to requirements for clinical coding, activity recording and submission of datasets is available as follows.

- Guidance on clinical coding, and Coding Clinic publications, can be accessed via the Resource Library page of the Delen system at https://nhsengland.kahootz.com/t_c_home/grouphome;

- Information Standards Notices are published at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/information-standards-notices; and

- Approved Collections relating to the NHS Standard Contract are listed at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/nhs-standard-contract-approved-collections.

44.34 Since commissioners can access and view new guidance of this kind in the same way that providers can, the provisions of SC28 make it explicit that providers are not required to give advance notice to commissioners of their intention to implement changes to the counting and coding of activity as a result of specific, new formal national guidance (that is, a nationally mandated change).

44.35 Rather, the expectation in the Contract will be that the provider will automatically implement any nationally mandated change on the date required in the relevant national guidance – but will inform the commissioner when it commences implementation, so that the parties can then discuss and agree appropriate payment adjustments to neutralise the financial impact, as described further below. (At the point of informing the commissioner of implementation, the provider should – as described at paragraph 44.27 above for locally proposed changes –

also give the commissioner its best available estimate of the impact of the change.)

Neutralising the financial impact of counting and coding changes

44.36 Whenever a counting and coding change is implemented, SC28 provides for time-limited protection against the financial effect (if there is one), by requiring that the parties must make a payment adjustment, so that the financial impact of each agreed change is rendered neutral in the short term. This applies to both locally proposed and nationally mandated changes.

44.37 What this means specifically is as follows.

For nationally mandated changes, the period of neutralisation is:

- where, for any reason, the change is implemented during the Contract Year during which the relevant new national guidance was published, for the remainder of that Contract Year; and

- in any event, for the full Contract Year following the Contract Year in which the relevant new national guidance was published.

For locally proposed changes, the period of neutralisation is:

- where, for any reason, the change is implemented during the Contract Year in which it was proposed, for the remainder of that Contract Year; and

- in any event, for the full Contract Year following the Contract Year in which the change was proposed.

44.38 For 2026/27, therefore, for locally proposed changes which are notified up to and including 30 September 2025:

- If a change is implemented with effect from 1 April 2026 or later, the financial impact is neutralised for the whole of the 2026/27 Contract Year.

- If a change is implemented before 1 April 2025, the financial impact is neutralised for the relevant part of the 2025/26 Contract Year and for the whole of the 2026/27 Contract Year.

- Where a reasonable estimate of the expected impact of a change can be made in advance, the parties should make a provisional neutralising adjustment, at the start of the Contract Year, to the Expected Annual Contract Value. But, in all cases, the parties will need to agree a process for monitoring the actual financial impact of the change in practice. Where an estimated up-front adjustment has been made, this can then be amended to reflect the actual impact through the year – and where no up-front adjustment has been made and in-year monitoring establishes that there has been an impact, an adjustment (both retrospective and ongoing, as appropriate) can be made as a result. SC28.15 sets out a requirement for the parties to approach this jointly and in good faith.

Delays in implementing changes

44.39 When new national guidance is published on activity recording or clinical coding, the expectation is of course that providers will implement this on the date or phased sequence of dates set out in the guidance; indeed, doing so is a contractual requirement. However, we recognise that implementation by a particular provider may occasionally be delayed – advertently or inadvertently. If the provider realises, after the mandated implementation date, that it has not implemented the required change, can it still do so as a nationally-mandated change – or must it now give notice of its intention to do so as a locally-proposed change?

44.40 Equally, where a provider has given proper notice of a locally-proposed change, and the parties have agreed that it should be implemented on a certain date, then the provider is under a contractual duty to implement the change on that date. But if the provider nonetheless fails to implement the change to the agreed timescale, what is the consequence? Can the provider still proceed to implement the change later than agreed, or must it give notice again in the next annual cycle?

44.41 A simple rule of thumb applies in both these situations. If actual implementation is delayed but still takes place within six months of the intended implementation date (either as set out in national guidance or, for locally-proposed changes, as agreed between the parties – in both cases, typically 1 April), then no further notice is required. If implementation is delayed beyond this point, the provider must notify the change (as a locally proposed change) by the next relevant deadline under SC28.11, and the period of financial neutrality will be extended accordingly.

Counting and coding changes for services with local prices

44.42 The provisions relating to counting and coding changes are of most relevance where services are being provided at National Prices. With services covered by Local Prices:

- the requirement for prior notification of proposed changes applies (so that neither party can be financially disadvantaged by application of an in-year counting change); and

- the impact of any proposed counting changes should be considered as part of the review of Local Prices for the following year, with the likely outcome being that the Local Price will be rebased to reflect the revised activity levels implied by the different approach to recording – this will have the effect of ensuring that any change is financially neutral.

What a provider should do if evidence of inaccurate recording emerges

44.43 There is inevitably a tension between the underlying requirement in SC28.7 that activity should be recorded correctly as required under relevant national guidance (the NHS Data Dictionary, for instance) – and the recognition, through the arrangements elsewhere in SC28 for locally-proposed counting and coding changes, that provider recording is, in practice, not always accurate. What does this mean for how providers should behave?

44.44 Technically, a commissioner could take the view that any instance of systematically inaccurate counting and coding amounted to a breach by the provider of its obligations under SC28. For the provider, therefore, the correct response on identifying such an instance is to notify the commissioner immediately of a locally proposed counting and coding change. By doing so, the provider is taking the appropriate action under the Contract to rectify the breach.

Implementation of local changes without prior notice

44.45 SC28.10 makes clear that providers must not implement local changes in counting and coding practice without prior notification and agreement. But if a provider nonetheless does so, what should happen?

44.46 Where a provider becomes aware only after the event that its staff have implemented a local change without proper prior notification of the commissioner, it must notify the commissioner at once, identifying the financial impact of the change as accurately as possible.

44.47 Similarly, if the commissioner is the first to become aware of such a change, it should notify the provider and, to protect its position, should contest payment for the financial impact of the change (as accurately as it can reasonably assess), at the earliest opportunity, under the arrangements for financial reconciliation at SC36. (Remember that a commissioner contesting payment under SC36.30 must always give its reasons "in reasonable detail"; so the commissioner should, in such an instance, set out to the provider proper evidence that a counting and coding change has taken place and that it has had the direct effect of increasing commissioner payments.)

44.48 In either case, because the provider has not given proper notice, the commissioner is likely to be justified in challenging payment in respect of any adverse financial impact for itself of the revised recording basis. This will apply both prospectively (until such point as proper notification of the change has taken place and the necessary period of financial neutrality has been enforced, as required under SC28) and retrospectively (to the date at which it contested payment under SC36.30).

44.49 If an un-notified counting and coding change is identified only well after its implementation, the question then arises as to whether the commissioner can properly seek retrospective financial protection back to the date of implementation, even if this pre-dates by some months the point at which the commissioner contested payment. Two points are relevant here.

- The wording on financial neutrality in SC28.9 and 28.14 now includes a reference to changes "found following implementation to have had" a financial impact. The intention of this wording is to ensure that neutralising financial adjustments are based on the actual impact of the change, not just on an in-advance estimate which may prove inaccurate. The wording of SC28 does not, however, create an automatic entitlement for a commissioner to receive financial redress for an un-notified counting and coding change back to the point of implementation.

- The provider may of course offer such retrospective redress voluntarily, but – if not – the commissioner may instead seek it using the provisions of GC11.2 (Liability and Indemnity). These provisions of GC11 allow either party to claim redress for losses it may suffer as a direct result of the other party's breach of contract. Note, however, that GC11.12 requires the party seeking to make such a claim to "take all reasonable steps to minimise and mitigate" its losses – so, for a retrospective claim under GC11 to be successful, a commissioner is likely to have to demonstrate that it has been vigilant in identifying and contesting the un-notified counting change at the earliest reasonable opportunity.

Assessing whether a change has happened and what its impact has been

44.50 Counting and coding changes are not always easy to identify or assess. There can be local disagreements over whether an un-notified change has actually taken place and over what the impact of a change (notified or un-notified) has been. This is particularly true where the issue relates to a gradual increase in the acuity of reported inpatient casemix, for instance, with an associated increase in the depth of diagnostic coding at episode level.

44.51 There are two important points here.

- Firstly, an un-notified counting and coding change is easiest to detect where it is a step-change – that is, for instance, where a provider reclassifies activity as daycase rather than outpatient. A change of this kind will usually be readily apparent from a straightforward analysis of commissioning datasets. However, a gradual but sustained change – for example, an increase over a year in the average number of diagnostic codes per episode in a particular service from three to four – may also be a counting and coding change. A counting and coding change does not have to be an "overnight" step-change.

- However, a reported increase in depth of diagnostic coding may have many potential explanations. A counting and coding change may be one (or indeed the only) factor in some cases. In other cases, an increase in reported casemix complexity for one commissioner may be explained by planned service developments / pathway changes or changes in patient flows between providers, change in attribution of patients between ICB and NHS England, genuine increase in patient acuity and, more basically, normal fluctuations in casemix from year to year – as well as, or instead of, a change in recording practice by the provider. So an increase in depth of coding cannot be automatically construed as a counting and coding change under SC28 of the Contract; that may be the explanation, or part of the explanation, or it may not, depending on the precise circumstances of the individual case.

44.52 Where issues of this kind arise – as SC28.15 requires – the local parties therefore need to review the evidence and work together, openly and in good faith, to reach a shared understanding, on the balance of probabilities, of what has occurred and what the financial impact has been.

Counting and coding changes and financial reconciliation and audit

44.53 Care must be taken to distinguish between:

- issues which a commissioner may legitimately challenge through the financial reconciliation process in SC36 and the audit process in GC15; and

- situations where the appropriate action is for the commissioner to propose a recording change under SC28.

44.54 Legitimate challenges under SC36 / GC15 may focus, for example, on inaccuracies in recording at individual patient level, allocating patients to the wrong commissioner, double-counting or inaccurate calculations. But where the commissioner questions a historically-established, systematically-adopted recording approach by a provider, use of which has informed the Expected Annual Contract Value agreed by both parties, then the correct approach will be for this to be handled as a locally-proposed counting and coding change under SC28, rather than as an issue to be handled in-year under SC36 or GC15. For the avoidance of doubt, this applies even where the provider's recording practice is not compliant with national standards and guidance.

44.55 By contrast, an audit under GC15 may appropriately be instigated by the commissioner as a way of assessing whether an un-notified counting and coding change has indeed taken place and what its financial impact has been. But, in such cases, it is essential that the audit is set up and undertaken as GC15 intends – with the Auditor acting as "an appropriately qualified, independent third party" (as the Contract definition in the General Conditions describes it), with a duty to establish the factual position impartially and objectively, taking into account all reasonable evidence and arguments. The role of the auditor under GC15 must not be confused with that of an external consultant to the commissioner. The auditor's role is emphatically not to provide the commissioner with advice on how best to interpret the evidence to its advantage; rather, GC15 must be used with the aim of providing the local parties with a "single version of the truth" from an authoritative, impartial source, albeit one appointed by the commissioner.

Conclusion

44.56 Although the Contract provisions on counting and coding changes remain absolutely necessary, we recognise that they can be complex to operate in practice. Many cases will be very clear-cut, but others will involve an element of interpretation and judgement, and quantifying the financial impact of counting and coding changes is not always a precise science. Good management of potential counting and coding changes will therefore rely on a reasonable approach from both commissioner and provider at local level. Both should work in good faith to the common goal that – while in the medium term the provider should be reimbursed in relation to accurately recorded activity – the aim of the contractual provisions on notification and financial impact of counting and coding changes is to avoid short-term financial gains or losses to either party. As we have noted above, the moves to system working and the API model for payments to Trusts should also make rigid application of much of the Contract mechanism for counting and coding changes increasingly unnecessary.

45 Contract management

The provisions in the shorter-form Contract for contract management are very significantly simplified. Either party may issue a Contract Performance Notice, and the parties may then agree and must subsequently implement appropriate remedial actions.

Contract review process

45.1 The contract review process is set out in GC8 (Review).

45.2 The necessary frequency of reviews will generally depend on the subject matter and size of the contract and the level of financial or clinical risk involved. The parties may agree a suitable interval between reviews, which should be at least every six months. The review frequency agreed should be set out in the Particulars. (Under the shorter-form Contract, we expect review meetings to be held as and when required, rather than on a fixed schedule.)

45.3 The matters for review will depend on the type of contract. Potential areas for review will include service quality, finance and activity, information, and general contract management issues. Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the quality and information schedules.

45.4 Either party may call an emergency review meeting at any time. Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.

Contract management process

45.5 The stages of the contract management process are set out in the flowchart below, but we have also clarified some points below about the way in which the process is intended to work.

We have simplified the contract management process for 2026/27 as follows:

- To make clear what actions either party may take in the event that the other party does not engage;
- To align the sanctions for failure to engage with the sanctions for remedy of a breach to remove any perverse financial incentive for non-engagement;
- To reduce the timeframe for the process by allowing a Joint Investigation to be agreed and begun at the first meeting;
- To remove the requirement to provide Exception Reports and instead clarify that the intended content of Exception Reports can be included in the Remedial Action Plan and therefore to remove Exception Report from GC17 and the definition of Suspension Event.

Informal queries and Contract Performance Notices

45.6 Factual queries to aid understanding should normally be handled informally between the parties or, if necessary, more formally as a request for information under SC28. By contrast, the formal Contract Management process is initiated through a Contract Performance Notice when either party has a clear understanding that the other has, or may have, breached a contractual obligation.

Joint Investigations

45.7 Where a Contract Performance Notice has been discussed and is not withdrawn, the default position is that either a Remedial Action Plan (RAP) is agreed (and/or, if the safety of patients, staff or the public is at risk, an Immediate Action Plan is implemented) or a Joint Investigation is undertaken (to be completed within two months).

Failure to engage or agree

45.8 The expectation in the Contract is that the parties will engage in good faith to remedy breaches of any contractual obligations. However, where the remedial process described at GC9.6 (Contract Management Meeting) or GC9.10-12 (Joint Investigation) is stalled for any reason, GC9.7 makes provision for the governing bodies of the parties to be notified. If, after a further ten Operational Days, it has still not been possible "due to unreasonableness or failure to engage on the part of the Provider" to move the process to the next stage of GC9, GC9.8 allows the co-ordinating commissioner to withhold a reasonable and proportionate sum of up to 10% of the Expected Monthly Value or of the Actual Monthly Value for each further month in which no progress is made.

Remedial Actions Plans and financial consequences

45.9 A RAP may set out both actions to be undertaken and improvements to be achieved and maintained, with the RAP setting out required timescales for each.

45.10 Clearly, the intention of a RAP is that it leads to remedy of the contractual obligation that has been breached. But the Contract sets out provisions which apply where this is not the outcome.

- By agreement, under GC9.14.3, a RAP may include reasonable and proportionate financial consequences (on either the provider or the commissioners) which are to be applied where the actions / outcomes set out in the RAP are not undertaken / achieved. Where this is the case, these consequences may be applied as soon as the breach of the RAP is clear.

- Alternatively, where no immediate financial consequences are agreed as part of the RAP itself and where the provider breaches the RAP, then under GC9.19, the co-ordinating commissioner may at this point withhold funding ("a reasonable and proportionate sum of up to 2% of the Actual Monthly Value" in respect of each action not completed or improvement not met, "subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Expected Monthly Value or of the Actual Monthly Value, as applicable").

45.11 These broader provisions for withholding funding under GC9 are deliberately available to the commissioner only – since the priority here is to protect services to patients, which it is the provider's role to provide. But note the following:

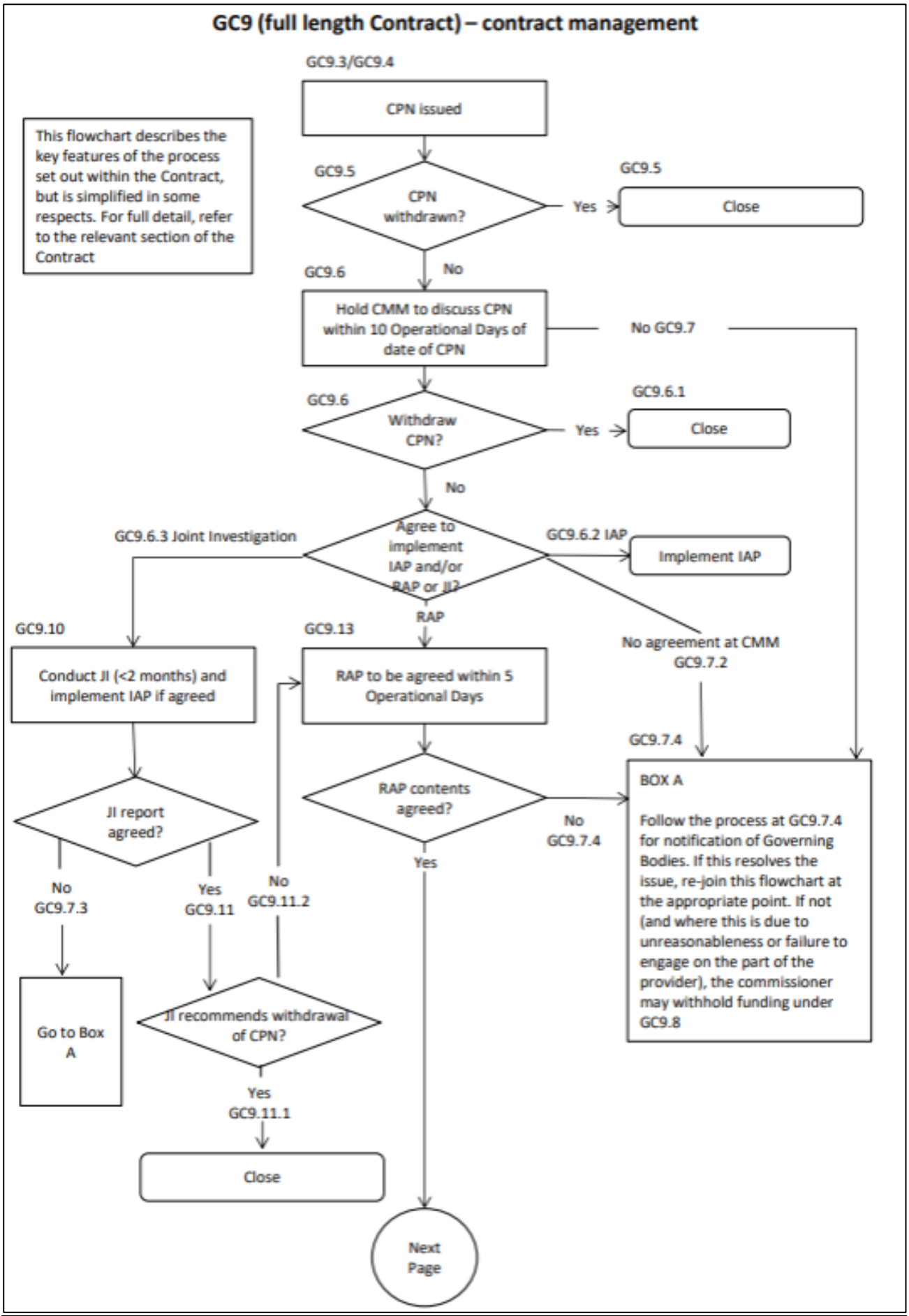
- We anticipate that these withholding provisions should need to be used only very infrequently – and any withholding must be "reasonable and proportionate", as the Contract wording requires. This is especially true in the context of the legal duties, under the Health and Care Act 2022, on ICBs and local partner Trusts to work together to deliver system financial balance.

- Funding is withheld temporarily in the first instance and is repayable to the provider, once the provider engages properly in the remedial process (if the withholding is under GC9.8) or fully implements an agreed Remedial Action Plan (if under GC9.19). Funding may only be retained permanently by commissioners in the specific circumstances set out in GC9.20 or GC9.22-23.

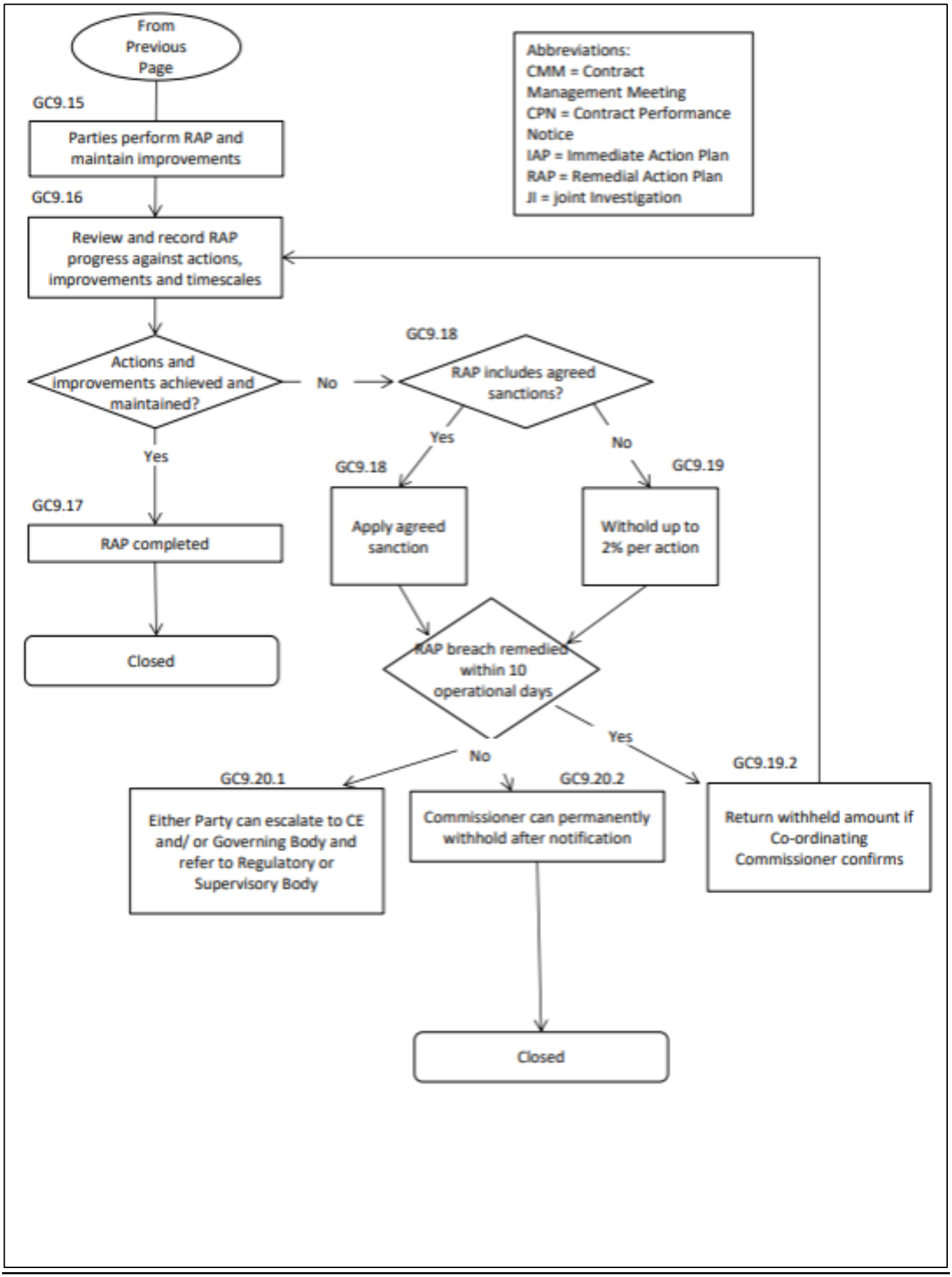
- Where a provider believes that a commissioner is refusing to address its own breaches of contract under GC9, it may a) pursue the matter through the dispute resolution process at GC14 and/or b) seek compensation under GC11 for losses which it can demonstrate that it has incurred as a direct result of the commissioner's breach of contract.

Breach of new national requirements in the Contract

45.12 The annual update of the NHS Standard Contract typically introduces a range of new policy requirements. Not all providers will be in a position to comply fully with all such requirements from the first day on which the new Contract takes effect. Where this is the case, commissioner and provider should discuss a prompt, but realistic, timescale for implementation, with this recorded in the local contract as a Remedial Action Plan or Service Development and Improvement Plan if required.



Yellow = updated from the 2025/26 versions of the Guidance published in April and September 2025
Grey = updated from the first version of the 2026/27 Guidance published in November 2025


From Previous Page
GC9.15
Parties perform RAP and maintain improvements
GC9.16
Review and record RAP progress against actions, improvements and timescales
Actions and improvements achieved and maintained?
No
GC9.18
RAP includes agreed sanctions?
Yes
No
Yes
GC9.17
RAP completed
Closed
GC9.18
Apply agreed sanction
GC9.19
Withold up to 2% per action
RAP breach remedied within 10 operational days
Yes
No
GC9.20.1
Either Party can escalate to CE and/ or Governing Body and refer to Regulatory or Supervisory Body
GC9.20.2
Commissioner can permanently withhold after notification
GC9.19.2
Return withheld amount if Co-ordinating Commissioner confirms
Closed
Abbreviations:
CMM = Contract Management Meeting
CPN = Contract Performance Notice
IAP = Immediate Action Plan
RAP = Remedial Action Plan
JI = joint Investigation

46 Payment

The payment provisions in the shorter-form Contract are similar to those in the full-length version but omit certain details. The shorter-form Contract no longer references CQUIN.

46.1 This section describes the contractual processes and schedules relating to the making of payments between the parties.

Note regarding CQUIN

There continues to be a 'pause' in place to the Commissioning for Quality and Innovation scheme (CQUIN) (which forms part of the Aligned Payment and Incentives Rules for Trusts within the NHS Payment Scheme).

In terms of the implications for the Contract, SC38.1 requires a CQUIN Scheme to be implemented "where and as required by the Aligned Payment and Incentive Rules and by CQUIN Guidance". As the pause to CQUIN is continuing, the Rules and Guidance will not require CQUIN to be implemented for the duration of that pause, and so the rest of SC38 will simply be redundant for as long as the pause continues, pending the outcome of the broader review of incentives. But those provisions could become "live" again if and when the pause is terminated. We have therefore not proposed any specific changes to the Contract wording at this stage as a result of the CQUIN pause.

References to CQUIN in the Guidance below should be read in this context.

Payment schedules

46.2 Under the Health and Care Act 2022, the previous National Tariff Payment System has been replaced by the NHS Payment Scheme. Prices payable under an NHS Standard Contract must always be agreed in accordance with the rules set out in the NHS Payment Scheme.

46.3 The wording of SC36 and the relevant Schedules (3A-F) reflect the approach and terminology in the NHS Payment Scheme for 2026/27.

46.4 Under the 2026/27 NHS Payment Scheme, the approach to the pricing of Services varies depending on the type of provider.

- All non-NHS providers (that is, providers which are not NHS Trusts or NHS Foundation Trusts) will be paid,
    - for certain elective acute services, on the basis of Unit Prices published under the "activity based payment" rules at section 6 of the NHS Payment Scheme (note that the Contract deliberately does not contain a specific schedule where relevant Unit Prices are to be recorded; rather,

the published Unit Prices, subject to applicable MFF and specialist top-ups, apply automatically); and/or

- for all other services, on the basis of Local Prices, agreed in accordance with the 'local payment arrangements' rules at section 7 of the NHS Payment Scheme.

- All NHS Trusts and NHS Foundation Trusts will be paid primarily on the basis of the 'aligned payment and incentive' (API) rules at section 4 of the NHS Payment Scheme.

  - In respect of services in scope of rules 4 and 5 of the API rules, Trusts will be paid on the basis of agreed Local Prices.

46.5 Locally agreed details relating to prices and payment are to be recorded in Schedule 3, as set out below. Not all of the sub-schedules with Schedule 3 will need to be completed for every contract. Schedule 3A on API will only be used for Trust contracts, for example.

- Schedule 3A records agreed API arrangements for each commissioner-Trust relationship. Detailed guidance on completion of this schedule will be published in the 2026/27 NHS Payment Scheme.

- Schedule 3B records any Locally Agreed Adjustments to Unit Prices. These are local agreements between a commissioner and a provider to depart from the Unit Prices set out in the NHS Payment Scheme. Adjustments may only be agreed specifically as set out in the NHS Payment Scheme. The commissioner must publish any Locally Agreed Adjustments using the template provided by NHS England and must also notify the Adjustments to NHS England. See the NHS Payment Scheme for full details.

- Schedule 3C records Local Prices (including details of the basis on which payment is made for each locally priced Service – "activity x price", block payment, marginal rate etc). In the case of a contract covering more than one Contract Year, there is a specific provision (SC36.6) for the parties to record within Schedule 3C any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years.

- Schedule 3D sets out the Expected Annual Contract Value (EACV). This is the figure on which any payment on account is then based – see below for further detail. Note that, under SC36.12, an EACV must be agreed if the provider is an NHS Trust or an NHS Foundation Trust and may be agreed if the provider is a non-NHS organisation. This reflects the expectation that Trusts will operate under API and will therefore always have an agreed EACV.

- Schedule 3E allows for recording of timing of payments in the first or final contract year (required only where a local contract does not commence on 1 April or expire on 31 March).

- Schedule 3F would normally record the relevant national CQUIN indicators which a Trust is incentivised to achieve – but, due to the continuing "pause" on CQUIN, completion of this Schedule will not be necessary for 2026/27.

46.6 The arrangements for payment for high-cost drugs, devices and innovative products require explanation.

- A workbook published as Annex A to the NHS Payment Scheme identifies a range of specified high-cost drugs, devices and products, the costs of which have been excluded from Unit Prices.

- The NHS Payment Scheme sets a general rule for how these are to be paid for – the "excluded items pricing rule" at section 3.4.

46.7 What this means for provider payment is set out below.

- Where Unit Prices or Local Prices apply, the items identified in Annex A above are therefore to be paid for separately by commissioners, in addition to the Unit Price or Local Price.

- Where payment for a drug, device or product is to be made separately, this is generally handled on a "pass-through" (i.e. actual cost) basis, but – under the "excluded items pricing rule" – specific prices for some items may in some cases apply or be agreed. There should generally be no need to list all of the excluded items in any of the schedules above, but any specific agreements on prices for excluded items do need to be recorded in Schedule 3C.

- The EACV in Schedule 3D can – where agreed locally – include an estimate for any excluded items, with in-year reconciliation to ensure final payment reflects actual costs; this approach will mean that that the provider receives an in-advance payment in relation to the excluded items. Otherwise, payment for excluded items can be purely retrospective.

Invoicing, payment and reconciliation

46.8 Detailed arrangements for invoicing, payment and financial reconciliation are set out in SC36 and in the flowcharts below. Note the changes, from 2024/25 onwards, to the language of SC36 in relation to invoices. Historically, payments to providers under the Contract have been made on the basis of an invoice submitted by the provider to the commissioner. This remains the case for non-NHS providers, but payments from commissioners to Trusts are now to be made on the basis of a different, less burdensome approach, the "invoice payment file" described further in the Revenue, Finance and Contracting Guidance. Under this approach, commissioners make payments to Trusts, without the need for submission of invoices and based instead on discussion and agreement in advance of values to be paid.

46.9 The arrangements will vary between contracts in a number of ways.

- **EACV agreed with block payment.** The simplest arrangement will be where the commissioner and provider agree that the EACV will be paid on a block

basis, with no adjustments to payment to reflect actual in-year activity volumes. In this case, under SC36.13-14, the commissioner pays the provider the agreed amount, in advance, on the 15th day of each month. Note that, although the default remains that up-front payments are made in equal 12ths, SC36.13-14 allow the parties to agree a more realistic, tailored profile – to reflect expected seasonal patterns or the phased impact of recovery plans, for example.

- **EACV agreed with reconciliation required.** In this situation, commissioner and provider have agreed an EACV which is being paid in advance in the same way – but they have also agreed that payment will be adjusted in-year, for example to reflect whether the provider over- or under-performs against the Indicative Activity Plan in the contract. In this case, the commissioner makes monthly on-account payments as described above, but the provider also submits quarterly reconciliation (SC36.17-19) accounts to the commissioner, adjusting for any difference between the payment already made and the actual sum due. Reconciliation accounts are always submitted quarterly, but the arrangements and timescales differ depending on whether the provider is required to submit any data to SUS – see further detail below.

- **No EACV agreed (non-NHS providers only).** In this situation, the provider invoices retrospectively, on a monthly basis, for activity actually undertaken (SC36.23-24). Again, the arrangements and timescales differ depending on whether the provider is required to submit any data to SUS – see further detail below.

Invoicing and reconciliation under SUS

46.10 The provider must submit data to SUS in accordance with SUS Guidance (SC28.17).

46.11 Where the provider has an agreed EACV and provides any Services for which data must be submitted to SUS, then a two-stage reconciliation process (commonly referred to as "flex and freeze") applies for all the Services provided under the contract (SC36.17-18), with the provider submitting to the commissioner both a first and a final reconciliation account, in accordance with the national SUS process and timeline.

46.12 Key deadlines from the SUS+ Submission Timetable 2026/27, by which data for each month must be submitted, can be viewed at: Payment by Results guidance – NHS England Digital. The Reconciliation Inclusion date is what is informally known as the "flex" date and provides an initial non-binding view of the month's data. The Post-Reconciliation Inclusion date is the point at which a provider's submitted data for the month is "frozen" and may not subsequently be changed for payment purposes. The Delivery date in each case is the date on which the SUS data is made available for commissioners to view.

46.13 Reconciliation and retrospective invoicing, and validation by commissioners of provider data, take place in the context of these dates, as explained further below.

Data queries at the flex stage (SC36.29)

46.14 Providers should do all they can to make their data as accurate as possible at the initial flex stage. The Contract now includes a requirement at SC28.18 for there to be no more than 5% variance in volume of activity recorded between first and final reconciliation date and for no more than 5% of activity to remain ungrouped (i.e. HRG = Uz01Z).

46.15 Once the Reconciliation Delivery date for a month has passed, the commissioner can see the provider's SUS data and can raise any data queries from this point onwards. It is in the interests of both parties that such queries are raised – and answered by the provider – promptly, so that any inaccuracies in the data can be corrected by the freeze point for that month (the Post-Reconciliation Inclusion date) a month later. This is particularly important in giving providers the opportunity to recode any activity initially attributed to the wrong commissioner, so that they still have time to recoup income from the correct commissioner.

Quarterly reconciliation (SC36.17-18)

46.16 Where, as described above, quarterly reconciliation applies, the Contract requires the provider to submit, for each quarter:

- an initial (flex) reconciliation account by what the Contract calls the First Quarterly Reconciliation Date – that is, the relevant Reconciliation Delivery date in the table above; and

- a final (freeze) reconciliation account "within five Operational Days after the Final Quarterly Reconciliation Date" – that is, within five working days of the relevant Post-Reconciliation Delivery date in the table above.

46.17 The quarterly deadlines, in 2026/27 for submission under the Contract of quarterly reconciliation accounts to the commissioner are therefore as follows:

	Initial reconciliation account	Final reconciliation account
Quarter 1	Tuesday 21 July 2026	Friday 21 August 2026 plus five working days = Friday 28 August 2026
Quarter 2	Wednesday 21 October 2026	Friday 20 November 2026 plus five working days = Friday 27 November 2026
Quarter 3	Friday 22 Jan 2027	Friday 19 February 2027 plus five working days = Friday 26 February 2026
Quarter 4	Wednesday 21 April 2027	Monday 24 May 2027 plus five working days = Tuesday 1 June 2027

46.18 So, as an example, the initial reconciliation account for quarter 1 must be based on frozen SUS data for April and May (in each case frozen at the relevant monthly deadline shown in the table at paragraph 46.17 above) and flex SUS data for June. The final reconciliation account for quarter 1 must be based on frozen data

for April, May and June (in each case frozen at the relevant monthly deadline shown in the table at paragraph 46.17 above).

Monthly retrospective invoicing (SC36.23)

46.19 As described above, monthly retrospective invoicing only applies for non-NHS providers with no agreed EACV.

46.20 The provider must issue a monthly invoice to the commissioner "within five Operational Days after the Final Monthly Reconciliation Date" – that is within five working days of the Post-Reconciliation Delivery date in the table at paragraph 46.21 above. For example, for April 2026, the deadline for invoicing is Friday 19 June 2026 plus five working days – i.e. Friday 26 June 2026. The same approach then applies in each succeeding month.

Invoicing and reconciliation where SUS does not apply

46.21 The arrangements where SUS does not apply to any of the provider's Services are simpler.

- Where an EACV has been agreed, then the commissioner makes monthly payments in advance in the normal way under SC36.13-14. However, the provider then only submits a single quarterly reconciliation account (SC36.19) – there is no flex and freeze process. The quarterly reconciliation account must be submitted within 20 working days of the end of the relevant quarter.

- Where there is no agreed EACV (non-NHS providers only), invoices for actual activity undertaken must be submitted retrospectively each month (SC36.24). The invoice must be submitted within 20 working days of the end of the relevant month.

Other points

46.22 Throughout SC36, the onus is on the provider to submit invoices and/or reconciliation accounts and on the commissioner to validate these, paying uncontested elements promptly in line with the timescales set out in the Contract and challenging any contested elements through the process set out in SC36.30.

46.23 Note that guidance about technical aspects of financial reconciliation and invoice validation is available at https://www.england.nhs.uk/ig/in-val/. This provides advice on how to ensure that any processing of Personal Confidential Data, for the purposes of invoice validation, is undertaken lawfully.

Applicability and payment of CQUIN

Paragraphs 46.24-29 below describe the arrangements for CQUIN which would normally apply. As there is a continuing "pause" to CQUIN for 2026/27, these arrangements will not apply and should be ignored for the present.

46.24 Under the NHS Payment Scheme, CQUIN is covered by the API rules and applies only to NHS Trusts and NHS Foundation Trusts, not to other providers. See the NHS Payment Scheme and CQUIN Guidance for further detail.

46.25 As described at paragraph 46.4 above, the value of the CQUIN scheme, for any individual commissioner-Trust relationship, will be 1.25% of the total of the fixed API payment and the amount included in the Expected Annual Contract Value in respect of elective activity.

46.26 This value is to be paid in full to the provider in advance in monthly instalments, as part of the EACV. The provider reports its CQUIN performance periodically to the commissioner (via the CQUIN Performance Report), and there is an annual financial reconciliation (via the CQUIN Reconciliation Account), through which the commissioner will claw back any underperformance, depending on the provider's performance against the CQUIN indicators include in Schedule 3F. These arrangements are set out in SC38 and are managed by the co-ordinating commissioner on behalf of the other commissioners.

46.27 Any claw-back of CQUIN is calculated by reference to the opening value described at paragraph 46.29 above. CQUIN payments do not need to be adjusted to reflect changes in actual elective activity levels compared to the opening planned value.

46.28 It is important to distinguish correctly between the CQUIN Performance Report and the CQUIN Reconciliation Account.

- The CQUIN Performance Report is what demonstrates whether or not the provider has met the requirements of the relevant CQUIN indicators. If the commissioner wishes to challenge the content of the provider's CQUIN Performance Report (in other words, to disagree with the provider's report on its own performance), it can do so under SC38.4 – but it must do this within ten working days of receipt of the CQUIN Performance Report.

- The CQUIN Reconciliation Account sets out the provider's calculation of the financial impact, for the full Contract Year, of the agreed outcomes from the various CQUIN Performance Reports which it has submitted during that year. Again, the commissioner can challenge the content of the CQUIN Reconciliation Account (under SC38.8 the deadline here being five working days from receipt).

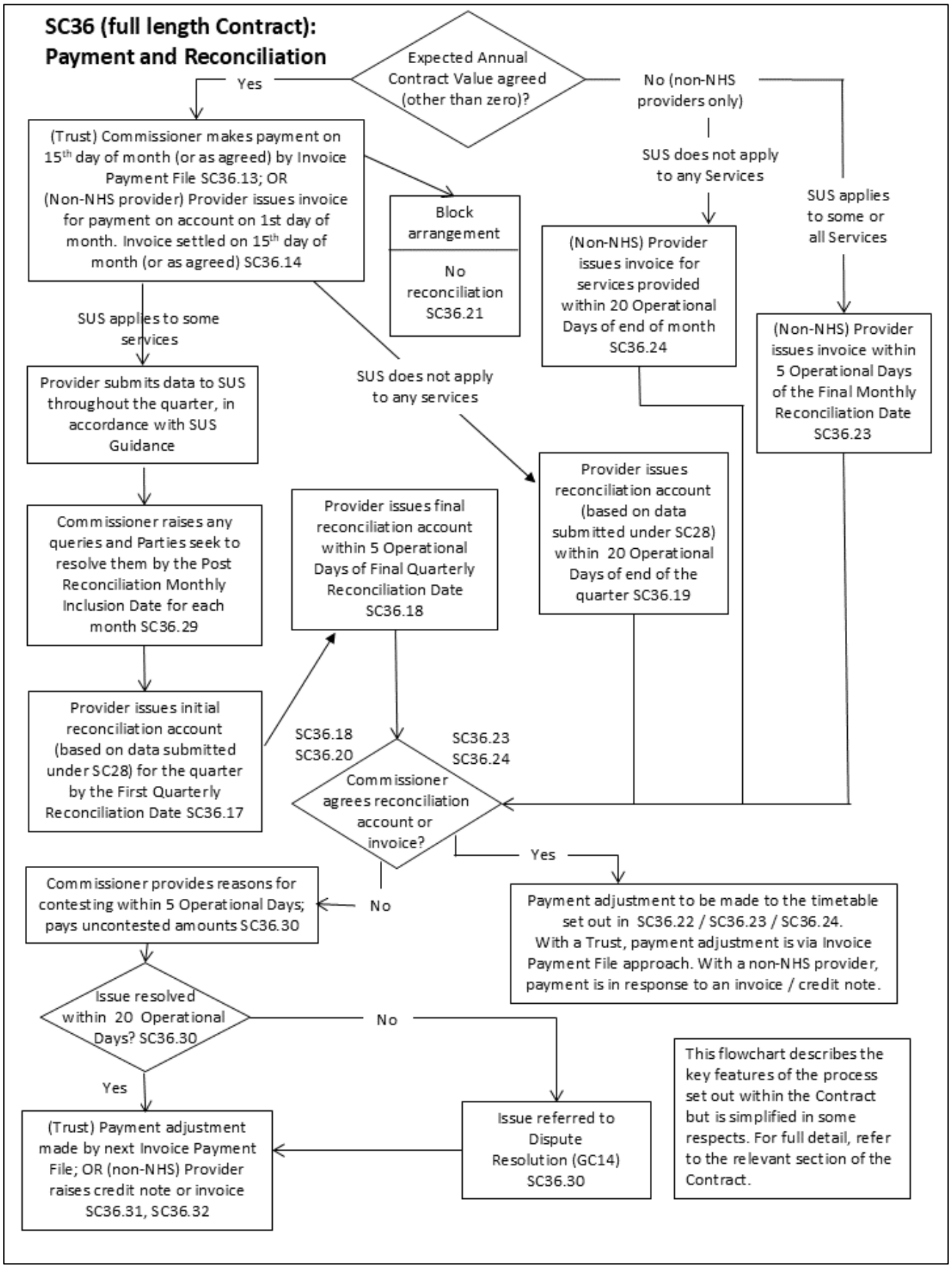
- The key point is that the CQUIN Reconciliation Account can only be challenged in relation to whether it "gets the maths right"- that is, whether it sets out accurately what CQUIN payment the provider is entitled to, reflecting the payment on account made and the level of CQUIN performance demonstrated. A commissioner cannot use the CQUIN Reconciliation Account process to challenge whether, in fact, the provider met the requirements of the CQUIN indicators; this must be done in relation to each CQUIN Performance Report as it is submitted during the year, in accordance with the timescales set out in SC38.4.

46.29 CQUIN is not referenced in the shorter-form version of the Contract, and CQUIN does not apply to Non-Contract Activity or in LVA arrangements.

Charging overseas visitors and migrants

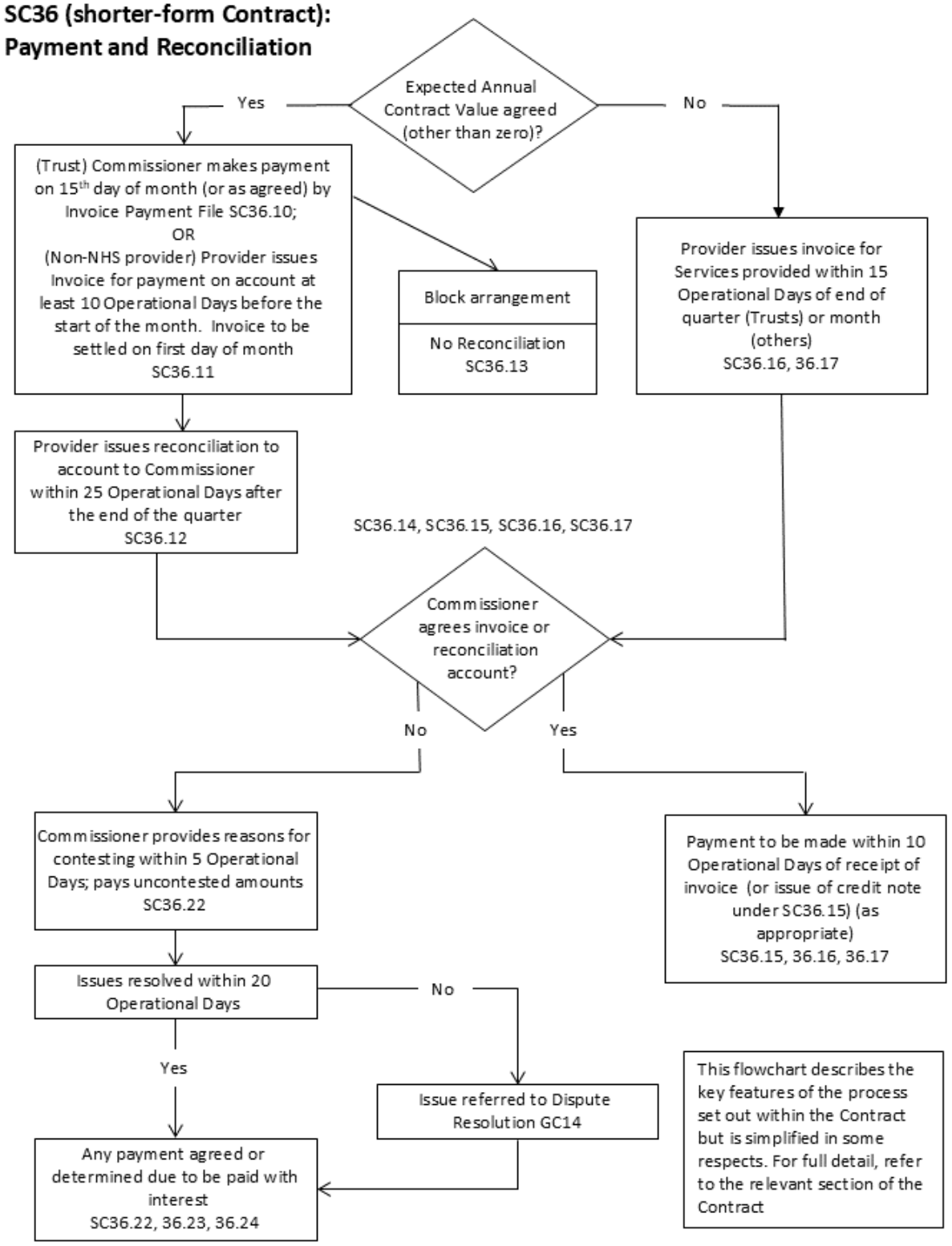
46.30 SC36.26 (full length Contract) / SC36.19 (shorter-form) contain requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the Regulations and guidance governing this area.

- Current DHSC guidance in this area, referred to in the Contract, is available at https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme and https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors/charging-overseas-visitors-in-england-guidance-for-providers-of-nhs-services. Resources for Trusts to help manage overseas visitors and migrant charging have been published by the Department of Health and Social Care and are available at https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants.



Yellow = updated from the 2025/26 versions of the Guidance published in April and September 2025
Grey = updated from the first version of the 2026/27 Guidance published in November 2025

SC36 (shorter-form Contract): Payment and Reconciliation



47 Other Contractual Processes

The provisions in the shorter-form Contract for variation, dispute resolution, suspension of services, termination of the contract and exit arrangements are all significantly abbreviated and simplified. Where necessary, additional locally agreed requirements may be included at Schedule 2G. As with the full-length version, optional provisions relating to staff pensions rights can be included within the shorter-form Contract at Schedule 7 where necessary.

Variation

47.1 Arrangements for varying contracts are set out in GC13 (Variations). The only variations which may be made locally to contracts are variations to locally agreed insertions, selections or content of the Particulars. Nationally-mandated elements of the NHS Standard Contract may not be varied locally (GC13.3), and it is essential that commissioners and providers do not try to vary, depart from or disapply the terms of the NHS Standard Contract as nationally mandated from time to time.

47.2 As explained at paragraph 33 above, from 2022/23 onwards, the GCs and SCs now exist in their up-to-date form online, as published by NHS England from time to time, and will be incorporated into, and will apply automatically as part of, each local contract by reference. This will mean that it will not be necessary for contracts in the 2022/23 or later form to be updated periodically via local signing of mandatory National Variations. References to National Variations have therefore been deleted from GC13. However, see paragraph 22.2 above for advice on updating non-expiring multi-year contracts for subsequent years. Commissioners and providers may agree Variations as permitted by GC13.3. The process for this is straightforward. In summary, the issuing party submits a draft Variation Agreement to the receiving party (a template is provided at https://www.england.nhs.uk/nhs-standard-contract/). The receiving party responds within ten operational days; there is discussion as necessary, and, if agreed, the final Variation Agreement is then signed by the co-ordinating commissioner and the provider, as set out at paragraph 21 above.

47.3 There is no specific period of notice which must be given for Variations. Rather, the agreed timescale for implementation should be set out in the Variation Agreement and should reflect the complexity of the issues involved and the time realistically needed to implement the specific changes proposed – and, of course, when the parties wish the changes to take effect.

47.4 The general principle in GC13 is that Variations proposed by either commissioner or provider only proceed where the other party **agrees** to the proposed Variation – but note the following points.

- An exception to this is set out in GC13.2 (full-length Contract) and GC13.2 (shorter-form version). Regulation 42D of the amended Standing Rules regulations describes the circumstances in which, and the process by which, a provider of services to which patients' rights of choice apply may ask a

commissioner to assess it for the award of a contract – or for its existing contract to be "modified" (i.e. varied) – to allow it to deliver new "choice" services, or to deliver "choice" services which it already delivers from a new location or subject to new accessibility requirements. Where the commissioner's assessment criteria are met, the commissioner must award the provider an appropriate contract or agree an appropriate modification to the existing contract, as the case may be. GC13.2 (full-length) and GC13.2 (shorter-form) therefore now make clear that commissioner may not refuse to agree a modification to the provider's contract where doing so would be contrary to these amendments to the Standing Rules Regulations.

- Otherwise, where any form of Variation is rejected by either party – and if that rejection is considered by the other party as a serious issue threatening the ongoing viability of the contract or of specific Services – the other party of course has the option of no-fault termination, on notice, under GC17 (GC17.2-3 in the full-length Contract, GC17.1-2 in the shorter-form version). Under the shorter-form Contract, this must be termination of the whole Contract (GC17.2), whereas under the full-length version there is also the option to terminate specific Services (GC17.2-3).

- Note also the specific termination right for the commissioner under GC13.13 and GC17.5 (full-length Contract only) in relation to any Service Variation refused by the provider. See the definition in the General Conditions for full detail, but a Service Variation is essentially a Variation which directly affects a specific Service. Where such a Service Variation is refused by the provider, the commissioner may terminate the affected Service by giving the provider not less than three months' written notice (or six months' written notice where the termination is likely to have a material adverse effect on the provider's staff).

47.5 Whenever a contract is being varied, the parties must ensure that they use, as the starting point for that Variation, the latest version of the contract (which may be the original contract or the contract as most recently updated by a signed and dated Variation Agreement). Parties to a contract should not progress more than one Variation to it in parallel or in competition with another, as doing so is likely to result in confusion and, potentially, dispute as to the terms of each proposed Variation and of the contract itself.

47.6 In relation to any variations, commissioners should take into account the provisions of regulations 13 and 14 of the Health Care Services (Provider Selection Regime) Regulations 2023 (which apply to all healthcare contracts, whether awarded before or after the PSR coming into force and whether or not they cover other, ancillary goods and services), and which limit the extent and scope of variations (or 'modifications') which may be made to existing contracts without a new provider selection process being undertaken). The parties should consider seeking their own legal advice before proceeding with any Variation, in order to ensure that the regime is being complied with.

47.7 We provide more information on the above issues in the slides and recording from our webinar Guidance on the contract variation process on our page on the FutureNHS platform.

Dispute resolution

47.8 The dispute resolution procedure (GC14) requires the parties in dispute to try to resolve their differences by negotiation, escalating to senior managers and then board-level representatives as required. If the dispute remains unresolved, the parties must refer it to mediation, under which the appointed mediator will attempt to facilitate the agreement of a satisfactory settlement of the dispute.

47.9 If mediation fails to resolve matters, the dispute must be referred to an independent expert for determination. The expert's ruling on the dispute will be binding on the parties.

47.10 The dispute resolution process at GC14 applies only once a contract is in operation. In relation to the agreement of new contracts, see paragraph 23 above.

Suspension

47.11 The provisions governing suspension of services are set out in GC16. It is worth commissioners reminding themselves of the scope which these provisions give to require a suspension, particularly when concerned about patient safety.

47.12 If commissioners and/or a regulatory body are concerned about the quality or outcomes of services being provided, or that the provider may not be meeting legal requirements (including, now, its duties in respect of the Fundamental Standards of Care), or about patient safety more generally, they should consider using commissioners' powers to require a suspension of services under the provider's contract. Services may be suspended until the cause of the suspension has been rectified and the provider is able to demonstrate that it can and will provide services to the required standard.

47.13 If considering exercising the right to require suspension of services on such grounds, commissioners should liaise with others commissioning services from the same provider, and of course with the regulatory authorities, with a view to acting in a concerted and consistent manner.

Termination

47.14 The provisions for termination in GC17 cover different circumstances under which the contract may be terminated – for commissioner default, provider default or where there is no fault.

No fault termination (GC17.1 – 17.8) (GC17.1 – 17.3 in the shorter-form)

47.15 GC17 makes explicit the ability of the parties to terminate the contract at any time by mutual consent.

47.16 It also provides for flexibility in the notice period required for either the provider or the co-ordinating commissioner (on behalf of all commissioners) to terminate the contract, or a particular service, in circumstances where neither is at fault. The notice period required for no fault termination is for local agreement (at the outset of the contract).

47.17 Under the full-length Contract, different periods of notice may be agreed for provider-instigated and co-ordinating commissioner-instigated termination, and the parties may agree that the right to terminate voluntarily may not take effect before a specific date (i.e. that the contract must be allowed to run for at least a set period of time before being terminated).

47.18 See paragraph 47.5 above in relation to termination under GC13.13 / GC17.5 where the provider refuses to accept a Service Variation to the contract.

47.19 Under GC17.8 (GC17.3 in the shorter-form), there is a right for the co-ordinating commissioner to terminate (on a no-fault basis) in specific circumstances as required by the Public Contracts Regulations (which will still be relevant to some older contracts) or equivalent provisions under the NHS Provider Selection Regime.

Termination for commissioner default (GC17.9) (GC17.4 in the shorter-form)

47.20 The provider may terminate the contract (as a whole or in respect of the relevant commissioner only) in the event of significant late payment or material breach on the part of a commissioner.

Termination for provider default (GC17.10) (GC17.5 in the shorter-form)

47.21 The Contract sets out (in abbreviated form in the shorter-form) the grounds of provider default on which the co-ordinating commissioner (on behalf of all commissioners) may terminate the contract or a service.

Consequences of expiry or termination

47.22 GC18 contains provisions governing what is to happen when the contract expires or is terminated, the primary objective of which is to ensure that the parties act in such a way as to effect a smooth transition of services and provider, with least inconvenience or risk to patients. This may involve the agreement (on or just before expiry or termination) of a Succession Plan (which might deal with patient handover, staffing matters, handover of premises and equipment and so on) with a new provider, and if so, all parties will be required to comply with their obligations under that plan.

47.23 Commissioners must ensure that they put in place clear arrangements with incoming and outgoing providers for the maintenance and storage of patients' health records at the expiry or termination of a contract. SC23.2 enables the commissioner to require an outgoing provider to deliver such records to a new provider (where they may be needed to support ongoing delivery of care or require storage until they have met the required retention period) – but, when putting in place the contract with an incoming provider, the commissioner itself must build into that contract clear requirements as to whether that provider will be expected to receive, store and maintain ongoing and/or historic records transferred from the outgoing provider. In that way, a situation will be avoided where neither the outgoing nor the incoming provider will take responsibility for records storage.

Exit arrangements

47.24 The parties may agree, at the outset of the contract, more wide-ranging actions and consequences to take effect on expiry or termination of the contract. These may include:

- arrangements in relation to staff and TUPE, supplementing the provisions of GC5;
- arrangements in relation to staff redundancies;
- arrangements for transfer of freehold or leasehold premises, or of major items of equipment;
- requirements for exit payments to be made by commissioners or by the provider, depending on the circumstances in which the contract (or provision of a service) comes to an end; and/or
- arrangements for the secure transfer of active and inactive Service User Health Records to the incoming provider or to any third-party provider.

47.25 Any such arrangements should be set out, as clearly as possible, in Schedule 2I (Exit Arrangements) (or Schedule 2G (Other Local Agreements, Policies and Procedures of the shorter-form Contract).

47.26 GC18.2 provides a right for commissioners, if the contract or a service is terminated for provider default, to recover from the provider additional costs they incur (over and above what they would have paid the provider) to secure provision of the relevant services for six months following termination.

47.27 Commissioners may feel it appropriate (depending on the nature of the contract and the relationship with the provider) to supplement this provision by including in Schedule 2I (or Schedule 2G of the shorter-form Contract) requirements for:

- payment of additional compensation by the provider to the commissioners in the event of termination for provider default, or of voluntary termination by the provider; and/or
- payment of compensation by the commissioners to the provider in the event of termination for commissioner default, or of voluntary termination by the commissioners (for example, to compensate the provider for otherwise irrecoverable capital expenditure incurred in the expectation of the contract running its full term).

47.28 Commissioners should consider taking expert legal and financial advice before agreeing exit arrangements and should refer to Treasury guidance.

Change in control, novation and assignment

47.29 It is important to distinguish correctly between the provisions for change in control at GC24 and the arrangements under which a contract may be novated or assigned.

- The change in control provisions apply where the legal entity which holds the contract remains the same, but the effective control of that organisation (through voting rights at general meetings), usually as a result of a transfer of shares, changes hands. (Note that the change in control provisions do not apply where the provider is a public company listed on a stock exchange.)

- By contrast, where the intention is that one of the legal entities which are a party to the contract should change, the process of assignment or novation may be considered, for which the consent of the co-ordinating commissioner is required. See paragraph 38.2 above.

TUPE (Transfer of Undertakings (Protection of Employment))

47.30 Note that the Contract no longer includes an obligation on commissioners (previously at GC5.16 in the 2015/16 Contract) to use reasonable endeavours to procure TUPE indemnities from an incoming provider in favour of the outgoing provider. This is because the "chain" of indemnities from outgoing and incoming providers (now at GC5.14 to 5.17) is now well-established: incoming and outgoing providers are given rights to enforce those indemnities directly by GC29 (Third Party Rights).

New Fair Deal for staff pensions

47.31 The Department of Health and Social Care has published guidance on the treatment of staff pensions on the transfer of staff from public bodies to the independent sector. The NHS Standard Contract includes provisions in line with that guidance:

- An entitlement under GC17.10.16 (GC17.5.7 in the shorter-form) for the co-ordinating commissioner to terminate the contract if the NHS Business Services Authority notifies the commissioners that the provider or any sub-contractor is materially failing to comply with its obligations under the NHS Pension Scheme (including those under any Direction/Determination Letter);

- Schedule 7 (Pensions), at which commissioners may (in the appropriate circumstances – i.e. where TUPE applies to transfer NHS staff to an independent sector provider or sub-contractor) include further provisions (template wording and guidance available on the NHS Standard Contract webpage dealing with, among other things:

    - the provider's obligations to ensure that transferring staff are able to stay, or remain eligible to become, members of the NHS Pension Scheme;
    - the offer of broadly comparable benefits, where appropriate; and
    - the treatment of pension benefits on expiry of termination of the contract or Services).

We strongly recommend that both commissioners and providers take expert legal advice in relation to NHS Pensions before seeking to use or amend Schedule 7.

Liability and Indemnity

47.32 We have received a number of queries in this area and have expanded this section of our Guidance in response.

47.33 GC11 (Liability and Indemnity) states that each commissioner is liable to the provider, and the provider is liable to each commissioner, and they are required to indemnify the other, in respect of losses, costs and claims suffered by one party as a result of the other's negligence or breach of contract. "Indemnify" means to protect someone from loss, costs and claims, by paying money to that person when a specified event happens.

47.34 Note that the acts and omissions of staff and sub-contractors are the responsibility of the provider for this purpose.

47.35 'Negligence' is an act or failure to act by a party which breaches a duty of care owed by that party to someone else. A provider, for example, will owe a duty of care to its patients, to its employees, and to visitors to its facilities, among others. The provider's actions or failures to act, whether in providing healthcare services or in maintaining its facilities and equipment, may cause physical injury or other harm to a person to whom the provider owes a duty of care. That may result in a claim for compensation by or on behalf of the person harmed, and – whether in relation to that claim or otherwise – may lead to expenses being incurred by a commissioner.

47.36 A "breach of contract" is a failure by a party to a contract to comply fully with its obligations under it. A provider, for example, may not deliver a commissioned service in accordance with the service specification in its contract, or may not provide information to a commissioner in the manner required and by the deadline set by its contract. In either case, the provider would be in breach of its contract. That breach of contract may cause the commissioner to incur costs in relation to further treatment for a patient, or in itself having to put information submitted by the provider into the format required by the contract. Note other examples given at paragraphs 42.42, 44.51 and 45.14 above.

47.37 If a commissioner or the provider incurs losses, costs or claims as a result of the other's negligence or breach of contract, the innocent party is entitled to be indemnified by the other (GC11.1, 11.2). Note however that each party must take all reasonable steps to minimise any losses, costs and claims for which it is entitled to be indemnified under the contract (GC11.12).

47.38 But the type of losses and costs which can be claimed from the other party under the contract will depend on whether they relate to death or personal injury or damage to property resulting from the negligence or breach of contract (in which case both direct and indirect losses and costs will be recoverable) or other effects of the negligence or breach of contract (in which case only direct losses are recoverable). (See GC11.1, 11.2 and the definition of Losses.)

47.39 A direct loss is any loss that is the natural result of the breach or negligence in the ordinary course of events. An example of recoverable direct losses would be the additional costs incurred by the commissioner when arranging replacement clinical services to cover for the provider's failure to deliver services in accordance with its service specification. Indirect losses are generally understood as losses that are not the natural result of the breach or negligence but arise from the particular or unusual circumstances of the case – the NHS Standard Contract definition of the term expands on this with examples.

47.40 A party to a contract is likely to need expert legal advice when considering whether another party is liable for losses it has incurred and exactly what may be recoverable from that other party.

47.41 Neither the provider nor a commissioner may cap or limit its liability to the other under the indemnities provided for under GC11, and the provider's liability is not limited to the amount it can recover under its insurance or other indemnity arrangements (on which see below).

47.42 If the parties agree, or it is decided through the dispute resolution process, that one party to a contract must pay money to the other under an indemnity obligation under the contract, the sum due can either be claimed from the first party as a one-off debt or be set off against any payment otherwise due to the first party from the party that has suffered the loss – see SC36.33. For example, if the provider has breached its contract and the commissioner has incurred a direct loss as a consequence, the commissioner may deduct its loss from the sum otherwise payable to the provider for services delivered.

47.43 The provider must put in place, and keep in place, insurance or other "indemnity arrangements" to cover its potential liabilities to patients and their dependents for negligence in providing or failing to provide healthcare, to its employees, to visitors and other members of the public. The provider may be providing other, non-clinical services, and if so it must maintain indemnity arrangements in respect of those as well. The provider must ensure that its sub-contractors have appropriate cover too. The provider must not require its employees to bear the cost of indemnity arrangements (GC11.3).

47.44 The commissioner's interest in these arrangements is in having comfort (i) that there is cover in place to meet patient and other claims should they arise and (ii) that the risk of such claims jeopardising the financial viability of the provider is mitigated.

47.45 NHS Resolution has published helpful guidance for NHS commissioners of clinical services seeking to ensure that providers with which they are proposing to contract have in place adequate indemnity arrangements.

47.46 Independent sector providers will typically have in place commercial insurance policies to cover public liability and employer's liability (insurance for the latter being a legal requirement).

47.47 NHS Trusts and NHS Foundation Trusts instead rely on NHS Resolution's Liabilities to Third Parties Scheme (LTPS) to cover these risks. Membership of

this scheme is not open to other types of provider.

47.48 NHS Trusts and NHS Foundation Trusts rely on NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) to cover potential liabilities for clinical negligence. Membership of this scheme is also available to other types of provider. Where a CNST member sub-contracts services under its NHS Standard Contract, the indemnity cover provided by that member's CNST membership extends to clinical negligence liabilities of the sub-contractor.

47.49 NHS Resolution's Clinical Negligence Scheme for General Practice (CNSGP) provides cover for clinical negligence in respect of activities carried out in connection with the delivery of primary medical services under GMS, PMS or APMS arrangements. This includes primary medical services provided under an APMS 'bolt on' arrangement included in Schedule 2L to an NHS Standard Contract. But note that if Schedule 2L is included in an NHS Standard Contract, the primary medical services to be provided under it must be clearly described in that Schedule: CNSGP cover will generally only apply to those specified primary medical services, and not to services commissioned under the composite NHS Standard Contract/APMS contract more generally. Under no circumstances should Schedule 2L be included in an NHS Standard Contract if none of the services to be delivered under that contract are primary medical services. CNSGP also covers activities connected to the provision of services other than primary medical services when they are carried out by the holder of a GMS, PMS or APMS contract and are ancillary to the services carried out under that GMS, PMS or APMS contract – and those ancillary services may be all or some of the services commissioned from that provider under a separate NHS Standard Contract. Where CNSGP covers activities under an NHS Standard Contract it will also cover activities of any sub-contractor involved in those activities.

47.50 Detailed queries on eligibility for or coverage of CNST, CNSGP or LTPS should be directed to NHS Resolution: Contact - NHS Resolution.

47.51 Commissioners should require their providers to produce evidence of appropriate insurance or other indemnity arrangements in respect of the provider and its sub-contractors (at the latest) as a condition precedent to service commencement (see Schedule 1A) and at regular intervals during the contract term (see GC11.4). Appropriate evidence might comprise confirmation in writing of membership of CNST, CNSGP and/or LTPS, and/or current insurance policy schedules, as appropriate. Where commercial insurance is being relied upon by the provider, the commissioner should ensure that it is satisfied that the sums insured (per claim and in aggregate) are adequate given the nature of the services and facilities, staff numbers etc, and that any excesses payable or exclusions from cover are acceptable. If in doubt, commissioners should seek advice from a reputable insurance broker.

47.52 It is very important that cover is maintained to meet claims made after (sometimes long after) a Contract expires or is terminated in respect of treatment delivered under it. That is why GC11.7 (GC11.3 in the shorter-form Contract) requires the provider to ensure that its indemnity arrangements to cover liabilities to patients remain in force "until … liability may reasonably be considered to have ceased" (in other words, until the statutory limitation periods on potential claims have expired).

47.53 We have, at the request of the Department of Health and Social Care and NHS Resolution, included, as GC11.8 (GC11.5 in the shorter-form Contract), a requirement to support the obligation under GC11.7/11.3 to ensure that "run-off" cover is in place. The provider must provide evidence that this cover is in place, and if it fails to do so the commissioner may put cover in place itself (which it would do by paying the appropriate additional contribution to NHS Resolution for CNST cover)) and charge the provider for the costs incurred in doing so (and a commissioner may consider withholding payments due to the provider at or near the expiry or termination of its contract until satisfied that cover is in place, to ensure that funds are available to the commissioner if necessary). This is to address concerns that an independent sector provider may go out of business following expiry or termination of a contract, leaving "uninsured" potential claims for its clinical negligence, and both Service Users and the public purse therefore at risk.

48 Status of this guidance

48.1 This Contract Technical Guidance is intended to support commissioners in using the NHS Standard Contract and sets out clear expectations for how certain aspects should be addressed. In the event of conflict between this guidance document and the Contract, the terms of the Contract will prevail. Commissioners and providers should seek their own legal advice as necessary.

49 Advice and Support

49.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact england.contractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general. If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.

Appendix 1 Summary guide to completing the Particulars

This Appendix provides a summary of the key elements of the Particulars which are for local agreement and completion prior to signature and a guide to some of the key clauses in the Contract.

We have shared the slides and recordings from our webinars 'Completing the Contract Schedules 1 and 2' on our page on the FutureNHS platform, and these provide a useful introduction to completing the Contract Schedules.

Initial advice on the general interpretation of NHS Standard Contract terms and use of the NHS Standard Contract is available via england.contractshelp@nhs.net.

The scope of the contract

The NHS Standard Contract (full-length or shorter form) may be used as:

- a multilateral contract to be entered into by a number of commissioners and a single provider; or
- a bilateral contract entered into by a single commissioner and a single provider.

For multilateral contracts, the roles and responsibilities table set out in the collaborative commissioning agreement will be used to identify the roles each commissioner will play in relation to the contract i.e. who will play the role of co-ordinating commissioner in respect of specific, or all, provisions in which the co-ordinating commissioner is mentioned.

The Contract contains provisions which are either:

- mandatory and non-variable, whether for all NHS services or only for specific types of service; or
- mandatory, but for local agreement and definition; or
- non-mandatory and for local agreement and definition.

	As explained in paragraph 33 above, the General Conditions and Service Conditions (as published online by NHS England from time to time) will be incorporated in their up-to-date online form into, and will apply automatically as part of, each local contract by reference only. All of the **General Conditions**, as applicable from time to time, will be mandated and cannot be amended or deleted or disapplied locally. They apply to all services and to all providers of NHS funded clinical services. The **Service Conditions**, as applicable from time to time, will apply automatically to all services or to the relevant service, as indicated, and will be mandated for all services or the relevant service, as appropriate. The Service Conditions applicable to the relevant service cannot be changed, amended, deleted or disapplied locally.	
	The **Particulars** contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green'. Action is required on all items that are amber coloured and must be completed prior to signing the contract. The parties must not leave any amber marked element for later completion.	

Yellow = updated from the 2025/26 versions of the Guidance published in April and September 2025
Grey = updated from the first version of the 2026/27 Guidance published in November 2025

	Any element indicated as ‘green’ is optional and may be left blank, although for good practice and clarity any ‘green’ element that is not used should be marked as ‘not applicable’.	

Where a term in the contract is capitalised, this means that the term is defined in the definitions section at the end of the General Conditions. Text in red highlights where the position differs under the shorter-form Contract.

Some of the Schedules in the Particulars contain guidance notes in italics, giving advice of what sort of content should or can be included. When completing an individual contract, delete these italicised guidance notes and include your own local agreed text or state “Not Used”.

We are often asked about the best way of populating the Contract schedules and, particularly, about embedding documents within contracts. Our recommendation has always been that either:

- text is entered in full into the relevant schedule itself, within the Particulars (this will work where the text is reasonably brief); or

- the schedule contains a reference to a separate document or spreadsheet which is then appended to the contract as a separate attachment.

We envisage that most complex contracts will need a series of such attached schedules, often in EXCEL, and it is obviously vital that there is a clear audit trail so that there can be no doubt as to the agreed final versions. Where it can be avoided, we do not recommend an approach where an embedded document is inserted within a schedule. There is a risk that the embedded documents may become corrupted and cease to open, in which case the agreed wording is lost.

We are also asked about whether requirements which are not applicable to the services being commissioned may be deleted from the Particulars. Our advice is as follows:

- Commissioners should not delete inapplicable requirements from the Particulars, in case of error. Any requirements which are not applicable to the services being commissioned are simply ‘read over’.

- Note that, in some of the schedules within the Particulars, guidance notes are included in italics. These should be deleted locally when the Particulars are completed.

Front page		
Contract title	Enter the local contract title and (if required) the services which are to be provided under the contract or a brief description of the contract	
Contract reference	Enter a local contract reference number or identifier.	
Particulars		
Date of Contract	Once the contract has been signed on behalf of all parties, that has been confirmed to all parties and all parties have agreed that the contract should be dated, that day's date must be inserted as the Date of Contract. This is the date the contract is legally executed and is not (necessarily) either the date from which it has been agreed it will be effective (the Effective Date) - or the date on which services start to be provided under it (the Service Commencement Date).	
Service Commencement Date	Enter the date when the services actually start delivery. This will usually be 1 April in the relevant year but will be the date agreed between the Commissioner and the Provider (the Expected Service Commencement Date) or the date on which any Conditions Precedent to Service Commencement (see GC3 and Schedule 1A) are satisfied, whichever is later. (See further below.)	
Contract Term	Enter the initial contract term, excluding any potential extension period (which may be stated in Schedule 1C), and the date on which that term begins (usually the Expected Service Commencement Date). Commissioners should refer to paragraphs 18-19 above regarding contract duration and any provisions to extend the contract.	
Commissioners	Enter the full legal name and address of each commissioner organisation (ICBs, NHS England and, if appropriate, the local authorities) which will be a commissioning party to the contract. Include the relevant ODS code for each as this will aid identification and is linked to the information flows. All Commissioners to this contract will need an ODS code. Information on ODS codes can be found at https://digital.nhs.uk/services/organisation-data-service	
Co-ordinating Commissioner	This is the Commissioner (or Commissioners) identified by the other Commissioners fulfilling the role (or roles) of Co-ordinating Commissioner for this contract. This links to Schedule 5C and the Collaborative Commissioning Agreement. Where the contract is a bilateral contract, the sole Commissioner will be the Co-ordinating Commissioner.	
Provider	Enter the full legal name, address and ODS code of the Provider.	
Contract award process	The Commissioner(s) must record here whether the specific contract was: • awarded under the Public Contracts Regulations;	

	• awarded under one of the different provider selection processes in the PSR; • awarded under the PSR urgency exemption; • awarded under the Procurement Act 2023; or, • called off under a specific framework compliant with regulation 18 of the PSR Under PSR, there must be one consistent single award process for each contract, covering all the services and commissioners. See also paragraph 15 above.	

Table of Contents		
Table of contents	The table of contents must not be changed.	
Contract		
Contract title	Populate as per the front page	
Contract reference	Populate as per the front page	
Signatures	The contract must be signed by an authorised signatory of each Commissioner which is a party to it, and by an authorised signatory of the Provider. Refer to paragraph 21 above. The date on which each signatory signs, and their title or position with the relevant organisation, should be inserted beneath their signature where indicated. Insert additional signature blocks as required for the number of Commissioners that are party to the contract.	

Completion of the tables in the Particulars headed **Service Commencement and Contract Term** and **Services** will determine whether certain of the Service Conditions or the content of certain of the schedules apply to the contract.

Service Commencement and Contract Term		
Effective Date	Insert the date on which the contract is to take effect (i.e. the date on which the rights and obligations on the parties become operational). This will usually be the Date of Contract but could be a later date.	
Expected Service Commencement Date	Enter the date(s) when the services are expected to start to be delivered. The Provider must satisfy all Conditions Precedent by this date. Services may not start until this is done.	
Longstop Date	This is the longstop date for satisfying Conditions Precedent. This should be no later than three months after the Expected Service Commencement Date in most instances. If the Longstop Date is reached and the Conditions Precedent have still not been met, the Co-ordinating Commissioner can then terminate the contract under GC17.10.1 (GC17.5.1). The longstop date must not be used to 'park' issues which the parties have not been able to agree by the time of contract signature, for later resolution.	

Contract Term	Enter the initial contract term excluding any extension period, and the date on which that term begins (usually the Expected Service Commencement Date).	
Option to extend Contract Term	Indicate here whether the Commissioners are to have an option to extend the term of the contract (noting and complying with guidance at paragraph 19 above), and the length of the permitted extension(s).	
Commissioner Notice Period GC17.2	Enter the Commissioner Notice Period for termination under GC17.2. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice.)	
Commissioner Earliest Termination Date GC17.2	Enter the earliest date on which a commissioner notice to terminate may take effect. (Not applicable under the shorter form.)	
Provider Notice Period GC17.3	Enter the Provider Notice Period for termination under GC17.3. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice.)	
Provider Earliest Termination Date GC17.3	Enter the earliest date on which a provider notice to terminate may take effect. (Not applicable under the shorter form.)	
Notice Period	Enter the notice period for termination by either the Co-ordinating Commissioner or the Provider.	
Service Categories		
Commissioners **must** select **all** the categories of service that are to be provided under the contract. Failure to indicate accurately which service categories are applicable will result in uncertainty as to which provisions of the NHS Standard Contract apply or do not apply to the contract in question. The selection of the services relevant to the Provider will determine which of the Service Conditions are applicable. The Service Conditions that are not applicable will be 'read over'. Where a service is added to or removed from an existing contract, this section will need to be updated. The process set out in GC13 (Variations) should be used. See paragraph 34 above for further detail on service categories. Note that the service categories listed in the shorter form are limited to those for which the shorter form may be used.		
Service Requirements		
Prior Approval Scheme Response Time Standard SC29.21	Indicate the timescale in which the relevant Commissioner must respond to a requirement for approval for treatment of an individual Service User under a Prior Approval Scheme to the Provider.	

Governance Note: the parties to a contract may prefer to keep a separate, shared record (available to and capable of being updated by each party) of the individuals holding each of the roles listed below and of their contact details, in a form which is easier to update from time to time than the Particulars themselves. If so, they are free to do so.		
Provider's Nominated Individual SC1.4 of the full-length Contract; definitions in the full-length and the shorter-form Contracts	The name and contact details of the Provider's Nominated Individual must be inserted here (this will be the same person as the nominated individual for the provider's CQC registration, where relevant). The Nominated Individual will be the person responsible for supervising the management of the Services, and such an individual must be identified whether or not the Provider is required to be CQC-registered for the purposes of the Services to be delivered under the Contract.	
Provider's Responsible Person for the Mental Health Units (Use of Force) Act 2018 SC3.17	Where required by the Mental Health Units (Use of Force) Act 2018, the name and contact details of the Provider's Responsible Person – the board-level individual with responsibility for overseeing its compliance with the Act – must be inserted here. (Not applicable to the shorter form.)	
Provider's UEC DoS Contact SC6.18	The name and contact details of the Provider's UEC DoS Contact must be inserted here. (Not applicable to the shorter form.)	
Commissioners' UEC DoS Leads SC6.18	The name and contact details of the Commissioner's UEC DoS Lead must be inserted here (ICBs only). Insert additional blocks as required for the number of ICBs that are party to the contract. (Not applicable to the shorter form.)	
Provider's Health Inequalities Lead SC13.8	The name and contact details of the Provider's Health Inequalities Lead Contact must be inserted here. (Not applicable to the shorter form.)	
Provider's Net Zero Lead SC18.2	The name and contact details of the Provider's Net Zero Lead must be inserted here. (Not applicable to the shorter form.)	
Provider's Infection Prevention Lead SC21.1	The name and contact details of the Provider's Infection Prevention Lead must be inserted here. (Not applicable to the shorter form.)	
Provider's Accountable Emergency Officer SC30.1	The name and contact details of the Provider's Accountable Emergency Officer must be inserted here.	
Provider's Safeguarding Leads / named professionals for safeguarding SC32.2	The name and contact details of the Provider's Safeguarding Leads / named professionals for safeguarding must be inserted here – separately for adults and children.	

Provider's Child Sexual Abuse and Exploitation Lead SC32.2	The name and contact details of the Provider's Child Sexual Abuse and Exploitation Lead must be inserted here. Note that this role is applicable for all services, including those provided just to adults, as children may visit the provider's site or come into contact with staff or service users.	
Provider's Mental Capacity and Liberty Protection Safeguards Lead SC32.2	The name and contact details of the Provider's Mental Capacity and Liberty Protection Safeguards Lead must be entered here.	
Provider's Prevent Lead SC32.2	The name and contact details of the Provider's Prevent Lead must be inserted here. (Not applicable to the shorter form.)	
Provider's Controlled Drugs Accountable Officer (NHS Trusts, NHS Foundation Trusts and English Independent Hospitals only) SC33.12	The name and contact details of the Provider's Controlled Drugs Accountable Officer must be inserted here. (Not applicable to the shorter form.)	
Provider's Wellbeing Guardian (NHS Trusts and Foundation Trusts only) GC5.9.3	The name and contact details of the Provider's Wellbeing Guardian must be inserted here. (Not applicable to the shorter form.)	
Provider's Freedom To Speak Up Guardian(s) GC5.10	The name and contact details of the Provider's Freedom To Speak Up Guardian(s) must be inserted here. More information on Freedom To Speak Up Guardians is available on the National Guardian website.	
Provider's Information Governance Lead GC21.3.1, GC21.3.4	The name and contact details of the Provider's Information Governance Lead must be inserted here.	
Provider's Data Protection Officer GC21.3.3, GC21.3.4	The name and contact details of the Provider's Data Protection Officer must be inserted here, where it is required by law to have one.	
Provider's Caldicott Guardian GC21.3.2, GC21.3.4	The name and contact details of the Provider's Caldicott Guardian must be inserted here.	
Provider's Senior Information Risk Owner GC21.3.2, GC21.3.4	The name and contact details of the Provider's Senior Information Risk Owner must be inserted here.	

Contract Management Note: the parties to a contract may prefer to keep a separate, shared record (available to and capable of being updated by each party) of the individuals holding the roles of Commissioner Representative and Provider Representative and of their contact details, in a form which is easier to update from time to time than the Particulars themselves. If so, they are free to do so.		
Frequency of Review Meetings GC8	Insert the frequency of the contract review meetings between the parties. The review meeting will focus on the quality and performance of the Services. The frequency of the review meetings should reflect the nature of the Services and the relationship between the parties. It is recommended that the minimum frequency should be every six months. (Not applicable to the shorter form; review meetings are to be held on an ad hoc basis.)	
Commissioner Representative(s) GC10.3	Insert for each Commissioner the name and contact details of the person who will be the primary contact point for the Provider. Where the ICBs have contracted with a commissioning support service, then the name and the contact details of the relevant contact point within the commissioning support service may be entered.	
Provider Representative GC10.3	Insert the name and contact details of the person who will be the Provider's primary contact point for the Commissioners.	
Nominated Mediation Body GC14.4	This links to GC14 (Dispute Resolution). Insert the details of the organisation that will act as the external mediator. Where the Provider is an NHS Trust or an NHS Foundation Trust, GC14.4.1 requires that mediation is arranged jointly by NHS England. (Not applicable to shorter form.)	
Addresses for service of notices GC36	Insert for each Party the name and address to which notices relating to the contract should be sent.	

Schedule 1 – Service Commencement		
A - Conditions precedent GC3, GC4	Insert details of any documents which must be provided and/or actions which must be completed by the Provider before it can start providing services. The items / actions on the list should be provided / completed prior to the Expected Service Commencement Date. Where this is not done by the Longstop Date, the Co-ordinating Commissioner is able to terminate the contract under GC17.10.1 (GC17.5.1). Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to: • Sub-contracts, see paragraph 38 above • Determinations / Direction Letters, see paragraph 47.31 above	

B - Commissioner Documents GC4.2	Insert details of any specific documents that have to be provided by the Commissioner(s) to the Provider prior to Service Commencement. (Not applicable to the shorter form.)	
C – Extension of Contract Term	To be used only as described in paragraph 19 above. Where applicable, insert the extension period of the contract, as advertised to potential providers during the procurement process.	
Schedule 2 – The Services		
A - Service Specifications	Commissioners and Providers should agree Service Specifications for all services commissioned under this contract. See paragraph 36 above for further details.	
2Ai – Service Specifications – Enhanced Health in Care Homes SC4.9	Indicative requirements marked YES are mandatory requirements for any Provider of community physical and mental health services which is to have a role in the delivery of the EHCH care model. Indicative requirements marked YES/NO will be requirements for the Provider in question if so agreed locally – so delete as appropriate to indicate requirements which do or do not apply to the Provider. The EHCH model is to cover all CQC-registered care home services, with or without nursing. Whether a specific care home is included in the scope of the EHCH model will be determined by its registration with CQC, which can be found by filtering column C in the CQC's 'care home directory with filters'. This directory is updated monthly. All care homes in this directory are in the scope of the EHCH service model. The specific care homes in that directory in respect of which the provider in question is to be involved in delivering the EHCH service model are to be agreed locally and listed in Schedule 2Ai where indicated.	
2Aii – Service Specifications – Primary and Community Mental Health Services SC4.10	Requirements shown are mandatory for any Provider of community mental health services which is to have a role in the delivery of the Primary and Community Mental Health Services Model. (Not applicable to the shorter form.)	
B – Indicative Activity Plan (IAP) SC29.5	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 42 above. The overall Indicative Activity Plan should include a breakdown of individual commissioner plans.	
C – Activity Planning Assumptions (APA) SC29.7	Insert any APA for the relevant Contract Year, specifying a threshold for each assumption. See paragraph 42 above for further details. (Not applicable to the shorter form.)	
F – Clinical Networks	Set out here any Clinical Networks in which the Provider is required to participate.	

SC26	If there are no relevant clinical networks applicable to the Services, enter 'not applicable'. (Not included in the shorter form, but if the Provider is to be required to participate in a Clinical Network the appropriate details may be included in Schedule 2G.)	
G – Other Local Agreements, Policies and Procedures SC25	If there are specific local agreements, policies and procedures with which the Provider and/or Commissioner(s) are to comply, enter details of them here.	
H – Transition Arrangements GC4	The contract Transition Period is the time between the Effective Date and the Service Commencement Date. There may be certain things that need to be done during that period in order that services commence smoothly. Details of any such arrangements should be inserted here. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 1A and/or Schedule 2G.)	
I – Exit Arrangements GC18.9	Where the parties agree specific payments to be made by one or more parties, and/or other specific arrangements which are to take effect, on the expiry or termination of the contract or termination or any service, these should be set out in this section. Where there are no exit payments or other arrangements, this section should be marked 'not applicable'. See paragraphs 47.24 – 47.28 above. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 2G.)	
J – Transfer of and Discharge from Care Protocols SC11	Any local agreement or protocols relating to Service Users' transfer and discharge from various care settings should be set out here. There is no mandatory format for this. A single protocol will not necessarily satisfy the needs of all types of Service User. Equally, separate local requirements for each Commissioner will need to be balanced against the provider's ability to accommodate different protocols for similar service users. Ideally, a single set of protocols will apply to all Commissioners. Where any individual Commissioner needs different transfer and discharge protocols, the collaborative commissioning group should discuss. Several protocols may be tabled for agreement with the Provider. The exact number will be for negotiation but it is expected that providers and commissioners will agree a sufficient number of different protocols broadly to satisfy local requirements without over-burdening the provider's ability to deliver.	
K – Safeguarding Policies and MCA Policies SC32	The Provider's written policies for safeguarding children and adults should be appended in Schedule 2K and may be varied from time to time in accordance with SC32.	

	The policy should reflect the local multi-agency safeguarding policy.	
L – Provisions Applicable to Primary Medical Services	See paragraphs 26.3 and 34.4 above. (Not applicable to the shorter form. If a package of general practice and secondary care services are being commissioned the full-length contract must be used, with Schedule 2L.)	
M – Development Plan for Personalised Care SC10.1	This optional schedule allows the parties to set out specific actions which each will take to implement the universal model of personalised care and to support the roll-out of personal health budgets. Further detail is provided within the schedule itself. (Not included in the shorter form.)	
N – Health Inequalities Action Plan SC13.7.2	This optional schedule allows the parties to set out specific actions which each will take, aimed at reducing inequalities in access to, experience of and outcomes from care and treatment. Further detail is provided within the schedule itself. (Not included in the shorter form.)	
Schedule 3 – Payment		
A – Aligned Payment and Incentive Rules SC36.3	Where the Aligned Payment and Incentives Rules apply, insert details as agreed locally for each relevant Commissioner, as shown in the schedule itself. (Not included in the shorter form.)	
B – Locally Agreed Adjustments to NHS Payment Scheme Unit Prices SC36.4.1.2	For each Locally Agreed Adjustment which has been agreed for this contract, copy or attach the template required – or state 'not applicable'. Additional locally agreed detail may be included as necessary by attaching further documents or spreadsheets.	
C - Local Prices SC36.4.2, SC36.6-10	Insert the detail of any Local Prices, entering text (or attaching documents or spreadsheets) for each separately priced Service, as shown in the schedule itself.	
D - Expected Annual Contract Values SC36.12	Insert the total Expected Annual Contract Value (EACV) for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). Where there is no EACV or an EACV of zero, enter 'not applicable'.	
E – Timing and Amounts of Payments in First and/or Final Contract Year SC36.15-16	If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here. Where the first and final Contract Year is 1 April – 31 March, enter 'not applicable'. (Not included in the shorter form, but if necessary appropriate provisions may be included in Schedule 3C.)	
F – CQUIN SC38	Note that, as the "pause" for CQUIN is continuing in 2026/27, as described in paragraph 46 above, this Schedule will not need to be completed in any contract for 2026/27 (Not included in the shorter form.)	

Yellow = updated from the 2025/26 versions of the Guidance published in April and September 2025
Grey = updated from the first version of the 2026/27 Guidance published in November 2025

Schedule 4 – Local and Locally-agreed Quality Requirements		
A - Local Quality Requirements	Commissioners may wish to agree other additional quality requirements with the Provider. Where these are agreed, they should also be recorded here. See also paragraph 39 above.	
B - National Quality Requirements with Locally-agreed Thresholds	Commissioners must add a local target for specified metrics, where a different target has been agreed with NHS England as part of the annual planning round.	
Schedule 5 – Governance		
A - Documents Relied On	If there are any documents, consents or certificates that have been relied on by any party in deciding whether to enter the contract, these should be identified and referenced here. However, the documents should not include letters of intent that relate to commissioning assumptions, nor should this schedule be used to endeavour to contradict or circumvent the mandated terms and conditions of the contract. (Not included in the shorter form.)	
B - Provider's Material Sub-contracts GC12	Details of any Material Sub-contracts should be inserted here. If the Sub-Contractor is processing Personal Data, state whether they are a Data Processor, Data Controller or joint Data Controller. If there are no Material Sub-contracts, this section will be identified as 'not applicable'. Further guidance is set out in paragraph 38 above. (Not included in the shorter form.)	
C - Commissioner Roles and Responsibilities GC10	If different Commissioners are to perform different Co-ordinating Commissioner functions, the Commissioners must set out in this schedule the roles and responsibilities that each Commissioner has in relation to this contact – in essence, who will be the Co-ordinating Commissioner for specific purposes under the contract. The roles and responsibilities should also be set out in the separate Collaborative Commissioning Agreement document entered into by all the Commissioners who are parties to the contract. (Not included in the shorter form.)	
Schedule 6 – Contract Management, Reporting and Information		
A - Reporting Requirements SC28	This table is used to set out the information that is required to be reported under the contract. See also paragraph 43 above.	
B - Data Quality Improvement Plans (DQIP) SC28.19	This table is used to record any agreed DQIP. See paragraph 43 above, which sets out certain situations in which a DQIP should be included and details when a DQIP must be included about SC28.18.	

	(Not included in the shorter form.)	
C – Service Development and Improvement Plans SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 41 above, which sets out certain situations in which an SDIP should be included. (Not included in the shorter form.)	
D – Surveys SC12.6	Insert here the requirements for frequency, reporting and publication of any locally agreed surveys. (Not included in the shorter form.)	
Schedule 6E – Data Processing Services		
Data Processing Services Annex B, Service Conditions, Provider Data Processing Agreement	This schedule is to be read and completed in conjunction with the Provider Data Processing Agreement. This schedule must be completed (and the terms of the Provider Data Processing Agreement will apply) **only where the Provider is acting as a Data Processor on behalf of one or more of the Commissioners**. Otherwise state Not Applicable. See the ICO Guidance on Data Controllers and Data Processors published at: https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/controllers-and-processors. **Update: International Transfers of Personal Data** The circumstances in which commissioners or providers transfer personal data to recipients abroad are likely to be limited. However, where such arrangements are in place or proposed they must comply with UK GDPR requirements as described on the Information Commissioner's Office (ICO) website. The following overview is provided for information only and should not be relied upon by commissioners or providers when considering international transfers: specialist legal advice (including as to any necessary additional information to be included in Schedule 6E) should be taken in those circumstances. Where a transfer is to a country recognised by the UK as having adequate arrangements for the protection of personal data, the transfer can be made on the same terms as if the transferee was located in the UK. All EU Member States and EU institutions and agencies are recognised by the UK as having adequate arrangements for data protection. A list of additional countries to which full or partial adequacy decisions apply is published on the ICO website. It should be noted that the USA is not included in this list. Where a transfer is to a country which has not been recognised by the UK as having adequate data protection arrangements, the data controller will need to undertake a Transfer Risk Assessment (TRA) to determine whether adequate safeguards can be put in place to facilitate the transfer. The most commonly used safeguard is likely to be	

	an International Data Transfer Agreement (IDTA). The ICO website provides comprehensive guidance on the use of TRAs and the IDTA.	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 47.31 above.	
Schedule 8 – TUPE		
TUPE	Applicable to the shorter form only. It may in certain circumstances be appropriate to omit the text of this schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken if considering using, and certainly before deleting or amending these provisions.	

Appendix 2 Supplementary definitions

This Appendix provides definitions for certain of the National Quality Requirements set out in Annex A of the Service Conditions.

For the other national requirements within Annex A, definitions are set out (or linked to) in Annex A itself.

Urgent operations cancelled for a second time

No urgent operation should be cancelled for a second time	
Definition	Include all urgent operations that are cancelled, including emergency patients (i.e. non-elective), who have their operations cancelled. In principle the majority of urgent cancellations will be urgent elective patients, but it is possible that an emergency patient has their operation cancelled (e.g. patient presents at A+E with complex fracture which needs operating on, but patient's operation is arranged and subsequently cancelled). The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) should be followed. Broadly these are: Immediate - Immediate (A) lifesaving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate. Urgent - Acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate. Expedited - Stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Operation target time within days of decision to operate. Elective - Surgical procedure planned or booked in advance of routine admission to hospital. Broadly, Immediate, Urgent and Expedited should be regarded as 'urgent' for the purpose of meeting this requirement. The full text of the NCEPOD Classification of Interventions is available online. An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. For postponements, the following apply: the 24 hour period is strictly 24 hours and not 24 working hours, i.e. it includes weekend / other non-working days; the patient should not be discharged from hospital during the 24 hour period; a patient cannot be postponed more than once (if they are then they count as a cancellation).
Rationale	Improved patient experience and patient outcomes.

Numerator	Number of urgent operations that are cancelled by the provider for non-clinical reasons which have already been previously cancelled once for non-clinical reasons.
Denominator	N/A
National data source	NHS England, monthly situation report (SitRep) collections https://www.england.nhs.uk/statistics/statistical-work-areas/critical-care-capacity/
Calculation	N/A
Operational standard	Operational standard is 0.

Ambulance service crew clear time following handover

Ambulance crew delays of over 15 minutes following clinical handover to hospital (including A+E) or Urgent Treatment Centre	
Definition	The guideline is that, following handover, the ambulance crew should be ready to accept new calls within 15 minutes. Data is collected to monitor the duration of time following clinical patient handover to crews becoming available. Handover Clock Stop: As defined in the AmbSYS specification, the time at which clinical handover has been fully completed (ambulance service) and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department. Crew Clear: Crew Clear performance (ambulance service) and the ambulance turnaround process as a whole: the time at which the ambulance crew has repatriated equipment, finalised paperwork, restocked where appropriate and cleaned the vehicle ready for the next call. Count all accident, emergency and urgent patients being handed over to A+E departments, to Urgent Treatment Centres and to other hospital units (such as Same Day Emergency Care Units, Medical Admissions Units and Surgical Admissions Units). This includes GP urgent patients brought by ambulance to A+E and other hospital units. Do not count non-emergency patients. Patients being transported between locations / Trusts / hospitals (e.g. for outpatient clinics, tertiary care) should not be counted.
Rationale	Delays in crews being ready to respond to further calls after handover are not acceptable. There are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A+E and other hospital units. Ambulance service capacity is severely constrained if crews do not promptly declare themselves clear to respond.
Numerator	Number of crew clear delays of over 15 minutes.
Denominator	N/A
National data source	N/A
Calculation	N/A
Operational standard	Operational standard is 0. (Note that, in monitoring provider compliance, commissioners should make allowance for exceptional occasions where delays beyond 15 minutes will be justified, for instance where a vehicle requires additional cleaning following a severe bleed, multiple casualties or in order to meet infection control requirements.)

VTE risk assessment

All inpatient service users undergoing risk assessment for venous thromboembolism (VTE)	
Definition	Inpatients aged 16 and over at the time of admission who have had a VTE risk assessment on admission to hospital using the clinical criteria of a national tool including: surgical inpatients; inpatients with acute medical illness (e.g. myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease), trauma inpatients or trauma patients discharged from A+E who are immobilised with a cast or brace; patients admitted to intensive care units; cancer inpatients; people undergoing long-term rehabilitation in hospital; patients admitted to a hospital bed for day-case medical or surgical procedures; private patients attending an NHS hospital. The following specific groups of patients are not covered by NICE NG89 and are therefore outside the scope of this data collection: people under the age of 16 at admission; people attending hospital as outpatients (other than patients admitted to a hospital bed for day-case medical or surgical procedures, as listed above); people attending hospital emergency departments who are not admitted as inpatients (other than patients being immobilised with a cast or brace); people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.
Rationale	Improved outcomes for patients. See NICE Guideline NG89 (https://www.nice.org.uk/guidance/ng89).
Numerator	Of the denominator described below, the number who had a VTE risk assessment on admission to hospital using a tool published by a national UK body, professional network or peer-reviewed journal (including those whose needs for VTE prophylaxis were assessed using NICE guidance that requires universal VTE prophylaxis for a cohort).
Denominator	Number of Service Users in each Quarter who were admitted as inpatients (includes day cases, maternity and transfers, both elective and non-elective admissions) (subject to the exclusions described in the Definition section above).
National data source	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/venous-thromboembolism-vte-risk-assessment-collection
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage.
Operational standard	Operational standard is 95%.

Sepsis identification, screening and treatment for Service Users presenting as emergencies

Proportion of Service Users presenting as emergency admissions who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis	
Definition	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis.
Rationale	Improved outcomes for patients. See NICE guideline NG253 (Suspected sepsis in people aged 16 or over: recognition, assessment and early management) at: https://www.nice.org.uk/guidance/ng253/chapter/Managing-suspected-sepsis
Numerator	Of the sample described below, the number who – following screening – were identified as at high risk of severe illness or death from sepsis and received IV antibiotics within one hour of diagnosis. This timing starts from when the clinical decision maker has decided the patient has suspected sepsis and stops when effective antibiotics have been administered.
Denominator	A locally audited random sample of 50 Service Users (adults arriving in hospital as emergency admissions) in each Quarter who were at high risk of severe illness or death from sepsis as defined in NICE guideline 51 (Suspected sepsis: recognition, diagnosis and early management).
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage and is assessed on a random sample of 50 Service Users each Quarter. Providers with low activity should calculate performance on the basis of all suspected patients if there are fewer than 50 per Quarter.
Operational standard	Operational standard is 90%.

NB: standard excludes pregnant women and children aged under 16.

Sepsis identification, screening and treatment for inpatient Service Users

Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis	
Definition	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis.
Rationale	Improved outcomes for patients. See NICE guideline NG253 (Suspected sepsis in people aged 16 or over: recognition, assessment and early management) at: https://www.nice.org.uk/guidance/ng253/chapter/Managing-suspected-sepsis
Numerator	Of the sample described below, the number who – following screening – were identified as at high risk of severe illness or death from sepsis and received IV antibiotics within one hour of diagnosis. This timing starts from when the clinical decision maker has decided the patient has suspected sepsis and stops when effective antibiotics have been administered.
Denominator	A locally audited random sample of 50 Service Users (adults treated in an inpatient ward) in each Quarter who were at high risk of severe illness or death from sepsis as defined in NICE guideline 51 (Suspected sepsis: recognition, diagnosis and early management).
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage and is assessed on a random sample of 50 Service Users each Quarter. Providers with low activity should calculate performance on the basis of all suspected patients if there are fewer than 50 per Quarter.
Operational standard	Operational standard is 90%.

NB: standard excludes pregnant women and children aged under 16.

Follow up from psychiatric in-patient care

The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	
Definition	All people discharged from ICB-commissioned inpatient mental health services should be followed up within 72 hours. This applies to everyone who is discharged from an ICB-commissioned adult mental health inpatient bed to their place of residence, care home, residential accommodation, or to non-psychiatric care. All avenues need to be exploited to ensure patients are followed up within 72 hours of discharge.
Rationale	There is evidence that people are at greater risk of dying by suicide in the period shortly after discharge from hospital. The latest report in 2018 from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), which provides findings relating to people who died by suicide in 2006-2016 across the UK, showed that in 2016 there were 227 suicides in the 3 months after hospital discharge. This equated to 17% of all patient suicides that year. Further, the highest risk is shown to be in the first 2 weeks after discharge, with the highest number of deaths occurring on day 3. While the overall rate of post-discharge suicide has reduced since 2011, the proportion of people who died in the first week after discharge did not change over the full reporting period (2006-2016). This provides compelling evidence that all patients are followed up within 3 days post discharge and the report recommends this as a key measure that services should take to reduce patient suicide risk. By completing follow up within 72 hours, providers are therefore supporting the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge. While the central metric of the new standard focuses on timeliness of follow up, the overarching expectation is that this will incentivise focus on overall quality of discharge planning and support. This is expected to have a direct impact on patient experience as well as outcomes.
Numerator	Of the denominator, those who have a follow up within 72 hours (commencing at 12am the day after discharge).
Denominator	Number of people discharged from an ICB commissioned adult mental health inpatient setting of the reporting period.
National data source	Mental Health Services Dataset.
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage.
Operational Standard	The operational standard is 80%

Waits in A+E from arrival to discharge, admission or transfer

Proportion of Service Users attending A+E who wait more than 12 hours from arrival to discharge, admission or transfer	
Definition	Proportion of Service Users attending A+E who wait more than 12 hours from arrival to discharge, admission or transfer.
Rationale	Better patient experience and more appropriate clinical care.
Numerator	Number of Service Users attending A+E during the period who wait more than 12 hours from arrival to discharge, admission or transfer.
Denominator	Number of Service Users attending A+E during the period
	For both numerator and denominator: • The measure is of the number of Service Users who have stayed in the A+E department for 12 hours or more since their arrival in the department. • All waits in excess of 12 hours should be counted, regardless of whether the patient is admitted, transferred or discharged. • The measure applies to all types of A+E department (types 1, 2 and 3). • The clock starts from the point at which the patient enters the department breaches if they have not left the department by the time 12 hours has elapsed.
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage.
Operational standard	Operational standard is no more than 2%.

Appendix 3 Which form of contract or agreement to use when

Some example scenarios are set out below to help organisations select the correct contract template.

Agreements between commissioners and providers

	Scenario	Recommended form
1	An ICB is commissioning a range of hospital inpatient and community mental health services from a local Trust.	The NHS Standard Contract (full-length version) must be used.
2	An ICB is commissioning and fully funding a single, community-based mental health service from a small charity.	The NHS Standard Contract must be used (use of the shorter-form version is recommended).
3	A charity provides a range of services and support for people with chronic disease. The local ICB does not commission any specific service from the charity, but wants to provide general financial support for its activities, to supplement its income from donations.	A grant agreement must be used (use of our model version is recommended, but not mandatory).
4	An ICB wishes to place an individual patient into an out-of-area care home for a package of NHS Continuing Healthcare.	The NHS Standard Contract must be used (use of the shorter-form version is recommended). (Where multiple placements are made into the same home, use of our model Individual Placement Agreement for each individual is recommended, alongside use of the NHS Standard Contract.)

	Scenario	Recommended form
5	An ICB wants to set up a service to provide blood pressure monitoring equipment for suitable patients to use at home. It intends to contract with a private company for this service. The company will supply and maintain the equipment, but will not be involved in patient treatment or in advising patients about their clinical care.	The NHS Standard Contract must not be used. Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended.
6	NHS England has delegated responsibility for commissioning primary medical services to an ICB. The ICB has identified a sub-group of its population which is under-provided for in terms of core GP services. It therefore wishes to commission a new provider to provide list-based GP services for that population, and is keen to open the opportunity up to the broadest range of potential providers.	The NHS Standard Contract must not be used. An APMS contract should be used – see https://www.england.nhs.uk/gp/investment/gp-contract/.
7	An ICB is commissioning a non-emergency patient transport service using taxis; the provider will not be required to register with the CQC.	The NHS Standard Contract must not be used. Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The ICB may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a provider. The relevant framework agreement is likely to specify the form of contract to be used.
8	An ICB is commissioning a non-emergency patient transport service, using ambulances, for unwell patients requiring some level of clinical supervision; the provider will be required to register with the CQC.	The NHS Standard Contract must be used (in either full-length or shorter form version).

	Scenario	Recommended form
9	NHS England has delegated the function of commissioning primary medical services to an ICB. The ICB has identified a part of its area which is under-provided for, in terms of both routine GP services and urgent care. It therefore wishes to commission a provider to provide, under a single contract, both list-based and non-list-based GP services (primary medical services) and an open-access urgent care service (not primary medical services).	The NHS Standard Contract must be used, in the full-length version, with Schedule 2L included (the schedule which imports the relevant APMS provisions).
10	A local authority is commissioning NHS Health Checks from a GP Federation established as a Community Interest Company.	The local authority may choose its own form of contract. It may use the NHS Standard Contract if it wishes (and, if asked, we would recommend that it does so), but use of the NHS Standard Contract by a local authority in this scenario is not mandatory.
11	A local authority and an ICB are contracting jointly for a range of community-based health and care services, to be supplied by a private company. Each will sign, and make payments under, the contract with the provider.	The NHS Standard Contract must be used (in either full-length or shorter form version). Additional information can be included in local schedules as necessary to cover the specific requirements of the local authority.
12	A local authority and an ICB have agreed a s75 pooled budget, for a range of learning disability health and care services, under which the local authority is to act as lead commissioner, awarding contracts to providers in its own name only.	The local authority may choose its own form of contract. It may use the NHS Standard Contract if it wishes (and, if asked, we would recommend that it does so), but use of the NHS Standard Contract by a local authority in this scenario is not mandatory.

Sub-contracts and other agreements between providers

	Scenario	Recommended form
13	A Trust holds a full-length NHS Standard Contract with its local ICBs for elective and emergency acute hospital services. To maintain those services over the winter, it wishes to "buy in" additional capacity from a local independent sector hospital – so that it can arrange for appropriate patients to be transferred there for treatment.	The NHS Standard Contract must not be used. The Trust should instead put in place a sub-contract (use of our template sub-contract, in the full-length version, is recommended but not mandatory).
14	A Trust contracts out cleaning services, including for clinical areas, to a private company.	The NHS Standard Contract itself must not be used – but nor should our template sub-contract be used, because that is designed for use when sub-contracting clinical services. Instead, use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The Trust may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a contractor. The relevant framework agreement is likely to specify the form of contract to be used.

	Scenario	Recommended form
15	A Trust arranges for a mobile scanner, owned by a private company and operated by that company's clinical staff, to visit the Trust's site weekly, in order to provide extra scanning capacity for the Trust's NHS patients (a clinical service).	The NHS Standard Contract must not be used. The Trust should instead put in place a sub-contract (use of our template sub-contract, in the full-length version, is recommended but not mandatory). The private company may propose that its own preferred form of sub-contract is used; any Trust in this situation should take its own legal advice before agreeing to do that. The key is for the Trust to ensure that the sub-contract protects it by "flowing down" to the sub-contractor the relevant terms and conditions of its NHS Standard Contract with its commissioners.
16	A Trust buys in a communications and PR service from a private company.	Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The Trust may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a contractor. The relevant framework agreement is likely to specify the form of contract to be used.
17	Two NHS Trusts each rely on, and make payments to, the other for certain things in a mutual aid / collaboration arrangement. None of these things are "whole" clinical services; some relate to clinical time (where one Trust employs staff who spend some of their time working in the other Trust), some to non-clinical support services (where one provides a function such as HR which the other uses) and some to premises (where one uses buildings owned by the other to provide clinical services).	It is unlikely that any published template will be fit-for-purpose to document an arrangement which involves several types of contractual relationship (secondment, sub-contracting of non-clinical services, licence to use premises). It may be better to document the different arrangements separately, using the appropriate form in each case. Trusts may need to take their own legal advice on how best to document them.
18	A Trust 'buys in' clinical staff from a neighbouring private hospital to work in its operating theatres, as part of clinical teams managed by the Trust.	This is probably best characterised as a staff secondment arrangement. Neither the NHS Standard Contract nor our template sub-contract should be used. The two parties will need to document the arrangement on a locally agreed basis.

	Scenario	Recommended form
19	Two or more Trusts arrange to deploy staff on a flexible basis across their respective sites and services.	This is probably best characterised as a mutual staff secondment or staff sharing arrangement, on which we recommend Trusts refer to Enabling staff movement between NHS organisations: A toolkit for sharing staff appropriately and efficiently.

Note that scenarios 13-15 above (and elements of scenario 17) all involve sub-contracting.

- For those scenarios, therefore, under GC12.1 of the Trust's NHS Standard Contract with its commissioners, prior written approval is required from the co-ordinating commissioner for the sub-contracting (and, at the commissioner's option, the sub-contract itself).

- Under GC12.4, it is for the co-ordinating commissioner to determine whether or not the sub-contracts are Material Sub-Contracts. Each Material Sub-Contract should be recorded in Schedule 5B of the Trust's NHS Standard Contract.

- The definition of a Material Sub-Contract set out at the rear of the General Conditions refers to "a Sub-Contract for the delivery of any clinical or clinical support service which comprises (irrespective of financial value) all of any Service, or a significant and necessary element of any Service, or a significant and necessary contribution towards the delivery of any Service". In that context, in our view, it would probably be appropriate for all of the sub-contracts at 13-17 to be considered Material Sub-Contracts.

Appendix 4 Non-Contract Activity (NCA)
Frequently asked questions

Introduction

Paragraph 25 above deals with Non-Contract Activity or NCA. This appendix sets out the NCA FAQs originally published on the NHS Standard Contract FutureNHS page and answers to some of the questions which commonly arise about NCA.

For consistency, all of the questions are expressed from the perspective of an ICB which is operating, or being asked to operate, on an NCA basis with a provider. We often refer to this ICB as the "NCA ICB". Where we refer below to the "host commissioner" or "host ICB", we mean the one which has consciously commissioned a service from a provider and which holds a written signed contract for that service with the provider.

Contents

The questions are set out under the following headings:

1) The scope of the legal right of choice of provider
2) The qualifying contract
3) Prices and payment
4) Virtual / online services
5) Providers' sites / locations
6) Providers' sub-contracts
7) ICB local commissioning policies
8) Shared care
9) Interface or referral assessment services
10) e-Referral Service
11) Ensuring informed choice
12) Contract management processes
13) Differential treatment of referrals
14) Moving away from NCA arrangements

1) The scope of the legal right of choice of provider

Question 1

My ICB is not sure whether choice of provider and team applies to a particular service, so we are not clear whether we should allow and pay for NCA referrals to the provider. How do we confirm this?

The nature of the service **and** the referral route into it will, taken together, determine whether patient choice of provider and team applies. If you are uncertain whether choice applies in a particular case, study the qualifying contract in question (see below), refer to NHS England's Patient Choice Guidance and, if necessary, check with the national Choice team via their email helpdesk (england.choice@nhs.net).

2) The qualifying contract

Question 2

A provider has invoiced our ICB for choice activity on an NCA basis. We have asked to see the contract on which the provider is relying, and the provider has refused to share it. What should we do?

For choice services, the whole concept of NCA relies on a provider having a written NHS Standard Contract for the service in question with at least one ICB. This written contract is what the relevant legislation (the Standing Rules regulations) refers to as the "qualifying contract". The regulations state that the terms of this qualifying contract with one ICB apply to the provision of the choice service to any patient referred from another ICB.

In order to approve and pay invoices for choice NCA, therefore, an ICB needs to be confident that the provider has a qualifying contract for the relevant service in place with at least one ICB. It also needs to know the terms of that qualifying contract – especially the price for the choice service provided.

So it is entirely reasonable that, where a commissioner receives an invoice for the first time from a provider with which it does not have a written contract, it asks the provider for sight of the relevant qualifying contract and any variations which have been made to it. We see no reason at all why a provider should refuse to share this on a complete and unredacted basis. The activity which the provider will be carrying out for the NCA ICB will be on the basis of that qualifying contract, and it is self-evidently in the public interest that the NCA ICB should be able to see the detailed terms under which patients for whom it is responsible are being treated. It cannot be argued, for instance, that the Local Prices in Schedule 3C of the qualifying contract are somehow to be kept confidential and not shared with the NCA ICB – because the provider must use those same prices as the basis for its invoice to the NCA ICB.

For those reasons, paragraph 25.16 above says "A provider wishing to provide services on an NCA basis must, on request, share with the NCA commissioner the full (including pricing) written, signed contract / contracts it holds with another commissioner / other commissioners and on which it is relying in order to undertake NCA – and, since 2025/26 , this is now a specific obligation under SC6.15 (SC6.4 in the shorter-form)."

Failure by a provider to share the full terms of a qualifying contract will create a reasonable doubt, for the NCA ICB, that the provider does hold such a contract and that

the price it is proposing to charge for NCA is the price in that contract. In such a situation, an ICB may reasonably decide to withhold payment unless and until the qualifying contract is shared in full.

Question 3

Our ICB has received an NCA invoice. We have asked the provider for a copy of its qualifying contract, and it has supplied a complete contract – but the dates in the Particulars show that the contract expired six months ago. Do we still have to pay the provider's invoice?

The requirement in the regulations is that the qualifying contract must be an NHS Standard Contract which "is signed and in effect before the date on which the referral is made". So if the referral to which this NCA invoice relates was made while the contract was in effect, you should pay it (even if treatment is then provided after the contract has expired).

Otherwise, you are under no obligation to pay the invoice. But do take a reasonable approach. If the term of contract supplied has expired, but the provider can provide evidence that the host commissioner is treating it as continuing (perhaps while the provider is waiting for new contract documentation from the ICB to sign), then you may be happy to pay the invoice.

Question 4

Our ICB has received an NCA invoice. We have asked the provider for a copy of its qualifying contract, and it has supplied a specification which it says is taken from its contract with a particular ICB. Do we have to pay the provider's invoice?

Provision of a specification alone is not sufficient to assure the NCA ICB that the provider has a qualifying contract. The specification will allow the NCA ICB to identify whether the service in question is indeed a choice service – but it does not confirm either that the contract is signed and in effect or what the agreed prices in the contract are. So the NCA ICB can reasonably decide to withhold payment unless and until the qualifying contract is shared in full.

Question 5

Our ICB has received an NCA invoice. We have asked the provider for a copy of its qualifying contract, and it has explained that it doesn't yet have a written contract with the host ICB. The host ICB is enabling GP referrals into the service, it is definitely a service to which patient choice rules apply, and the ICB is paying for the activity which results – but the ICB has just been slow in putting in place the necessary contract documentation. Do we have to pay the provider's invoice?

The provider appears to be operating on an implied contract with the host ICB – but it can only properly accept and treat NCA choice referrals from other ICBs where it has a qualifying contract which is "signed and in effect". That isn't the case here. So the provider is not legally entitled to accept NCA referrals (until such point as its contract is signed), and the NCA ICB is under no obligation to pay for activity arising, although it may choose to do so if the provider has provided satisfactory evidence of the terms and conditions it has agreed with its host ICB.

Question 6

Our ICB has received an NCA invoice for activity in the specialty of Gastroenterology. We have asked the provider for a copy of its qualifying contract, and it has supplied a copy, complete and unredacted – but it covers only Ophthalmology, not Gastroenterology. Do we have to pay the provider's invoice?

No. The provider must hold a qualifying contract for the relevant service. You should not pay the invoice and should make clear to the provider that it must not accept further referrals from your GPs into its Gastroenterology service.

Question 7

Our ICB has received an NCA invoice from a new provider. We have asked the provider for a copy of its qualifying contract, and it has supplied a sub-contract which a local Trust has awarded to it. Do we have to pay the provider's invoice?

No. The regulations make clear that a qualifying contract must be an NHS Standard Contract with an ICB or NHS England. That isn't the case here. So the provider must not accept NCA referrals, and the NCA ICB is under no obligation to pay for activity arising.

Question 8

Our ICB (ICB A) has received an NCA invoice from a new provider. We have asked the provider for a copy of its qualifying contract, and it has supplied a contract with an ICB (ICB B) for a consultant-led outpatient service. But the specification in the contract is very explicit that that the service being commissioned is only for patients for whom ICB B is the responsible commissioner. In that situation, is the provider prevented from

accepting GP referrals from our ICB (ICB A), and are we therefore entitled not to pay the provider's invoice?
No. ICB A may reasonably state in its specification that its intention in commissioning the service is to secure access to the service for its population. But that will not prevent the legal right of choice from applying to that service for patients referred from other ICBs. That's the position created by SC6.13, which (under GC1.2) would take precedence over anything written in a specification in the Particulars.

Question 9 Our ICB has received an NCA invoice from a new provider. We have asked the provider for a copy of its qualifying contract, and it has supplied a contract with an ICB for a consultant-led outpatient service. But the specification in the contract makes clear that the provider is only allowed to accept onward referrals from the ICB's local Trust's waiting list, not referrals direct from primary care. Do we have to pay the provider's invoice?
No. The legal right of choice of provider does not apply to onward referrals from Trusts. In this situation, the provider is not entitled to, and must not, accept referrals from other ICBs on an NCA basis.

Question 10 A provider has shared with us the Particulars of its NHS Standard Contract with ICB A for the consultant-led elective service required by one of our patients who has been referred to it. The Particulars describe where the service is to be delivered, and our patient is happy to attend that facility. The contract is signed by both parties and is dated with a date earlier than the date of the referral. But ICB A has told us that services have not commenced under that contract, because the provider has not yet satisfied all of the conditions precedent to service commencement set out in Schedule 1A of the Particulars. Is the contract with ICB A a qualifying contract? Is provider entitled to accept referrals of our patients before the conditions precedent under its contract with ICB A have been satisfied?
The NHS Standard Contract with ICB A is a qualifying contract for the referral in question, because: • It was signed and in effect before the date on which the referral is made; • It is a commissioning contract for the service required as a result of the referral; • It requires that service to be provided from the location specified in that contract or sets out the criteria to determine how that service will be accessible to patients; and • It is not a contract put in place solely to provide that service to a specified individual.

But the conditions precedent to service commencement apply both to the contract with ICB A and to an implied NCA contract with any NCA ICB.

So those conditions precedent to service commencement have to have been satisfied:

- under the qualifying contract, for services to start under it, and
- under the NCA contract, for services to start under it.

This means that referrals cannot be accepted and activity undertaken under an implied NCA contract before referrals can be accepted and activity undertaken under the qualifying contract itself.

We recommend that, when requesting sight of the Particulars of the NHS Standard Contract on which a provider is seeking to rely as its qualifying contract for a referral, commissioners also request evidence of the satisfaction of all conditions precedent to service commencement under that contract.

3) Prices and payment

Question 11

A provider has multiple "qualifying contracts" – all with slightly different local terms, including different local prices – for a particular choice service. Which of these contracts should it rely on for NCA purposes and which local price should apply?

The regulations don't deal with this issue specifically.

The most important thing is that the NCA ICB assures itself that the provider has at least one qualifying contract to underpin any NCA.

In the rare situation where a provider has multiple qualifying contracts for the same service delivered from the same location but with different local prices, our view is that – in the interests of value for public money – the provider should rely on the contract with the lowest price for any NCA which it undertakes from that location.

Question 12

NCA works well where pricing in the qualifying contract works on a simple "activity x price" basis. But what happens where the qualifying contract states a block price, a marginal-price "cost and volume" arrangement, or a "sliding scale" arrangement where the price becomes lower the more referrals are made?

Again, the regulations don't deal with this issue specifically.

The NHS Payment Scheme specifies that payment for many "physical health" elective services must work on an "activity x price" basis using nationally-set Unit Prices. And it will generally make sense for contracts for other "choice" services to work in the same way – because, with choice, the whole point is that you can't predict how many referrals an individual provider will receive.

Where a qualifying contract doesn't work in this way, that does pose some challenges – and it does mean that there may have to be some discussion and agreement between the provider and the NCA ICB. Here are two examples of what might happen.

Example 1

The service is a choice service, but the qualifying contract with ICB A states a block of £400,000 for 200 patients. One patient is then referred from ICB B as NCA.

ICB B (obviously!) doesn't have to pay the provider a block price of £400,000 for this one patient. A reasonable price for one additional patient, to be charged to ICB B, would be no more than £2,000 (£400,000 divided by 200 patients). That would be consistent with the approach taken in the qualifying contract.

ICB B could not reasonably argue that "we pay our local providers of this service only £1,000 – so that is all we are going to pay you for NCA" – because that would not be consistent with the qualifying contract. But, for the same reason, the provider could not reasonably argue that "our normal price for private patients for this service is £3,000 – so that is what we are going to charge you for NCA".

Example 2

The service is a choice service, but the qualifying contract with ICB C states a price of £2,000 for each of the first 50 of ICB C's patients, dropping to £1,500 for each subsequent ICB C patient. One patient is then referred from ICB D as NCA.

Our view here is that it would be reasonable for the provider to charge £2,000 for each NCA case treated until such point in the year as the threshold of 50 patients (in total – across ICB C and any NCA) is reached – and thereafter charge only £1,500 for each NCA case. That would be broadly consistent with the approach taken in the qualifying contract.

Many other scenarios could arise. Ultimately, if agreement can't be reached between the provider and an NCA ICB, the dispute resolution process in GC14 of the Contract can be followed – but, with a pragmatic, common-sense approach from both commissioner and provider (recognising the provider's fixed and variable costs, and that it should not expect higher margins in respect of an NCA ICB's patients than it does in respect of its host ICB's patients), it should be possible to avoid this.

Question 13

My ICB has received an invoice from an NCA provider. We have reviewed the qualifying contract and accept that the service is a choice service. The contract operates on the basis of Local Prices set out in Schedule 3C, but the Schedule states one Local Price to be charged to the host ICB and a separate (higher) Local Price to be charged to other ICBs for any NCA which arises. Does my ICB have to pay the higher Local Price?

No. The qualifying contract sets out the agreed terms which are to apply between the provider and the host ICB, including as to price. These terms then apply to any NCA. The qualifying contract should not be used in a way which purports to set out less advantageous terms which would apply to NCA. It is the Local Price which the host ICB is actually paying which must also apply to any NCA.

Question 14

My ICB has received an invoice from an NCA provider. We have reviewed the qualifying contract and accept that the service is a choice service. The contract covers services to which, under the NHS Payment Scheme, nationally-set Unit Prices apply. However, the qualifying contract makes clear in Schedule 3B that the host ICB and the provider have agreed a "local adjustment", as permitted under the NHS Payment Scheme rules, to reduce those Unit Prices to a lower level. But in its NCA invoice to our ICB, the provider has simply applied the Unit Prices, without the locally-agreed reduction. Does my ICB have to pay these full Unit Prices?

No. As above, the qualifying contract sets out the agreed terms which are to apply between the provider and the host ICB, including as to price. These terms then apply to any NCA. In this case it is the locally adjusted prices, which the host ICB has agreed with the provider, which must also apply to any NCA.

Question 15

My ICB never pays its local contracted providers for Did Not Attends (DNAs). But an NCA provider is asking for payment for DNAs. Does my ICB have to pay?

You need to check the qualifying contract. We would not generally advocate structuring a contract to provide for payment for DNAs, but if payment for DNAs is what the host ICB has agreed under the qualifying contract, then that is binding on NCA ICBs also. But any requirements in the qualifying contract for the provider to supply backing data to support its claim for payment for DNAs (and, indeed, any other Activity) will also apply to any NCA it undertakes – as will any provisions in the qualifying contract which require the provider to take action to minimise actual numbers of DNAs.

Question 16

My ICB has received an invoice for NCA from a provider. We know the provider and have previously confirmed that it has a qualifying contract. But this invoice has been received for activity which was completed six months ago – so it is outside of the deadline for invoicing in SC36. Does my ICB have to pay?

The deadlines for invoicing of NCA carried out in a particular month are set out in SC36.23 (where SUS applies) and SC36.24 (where it does not). An ICB is under no obligation to pay any NCA invoices received after these deadlines. Equally, where an ICB receives a timely invoice from an NCA provider and wishes to contest any element of payment, it must do so within the timescales set out in SC36.30 – but must otherwise make full payment in accordance with the timescales stated in SC36.23-24.

4) Virtual / online services

Question 17

My ICB has been invoiced by a provider of mental health services for virtual / online contacts with patients under NCA. The provider is based in a completely different part of the country, and we have never heard of them. Should we pay the invoice?

Many services can now be provided largely virtually / online, removing the need for patients to travel for treatment and enabling providers to offer their services on, in effect, a nationwide basis, as realistic choices for patients from any ICB.

So, again, you need to check the qualifying contract. But if choice applies and if the contract is clear that what the ICB has commissioned is, or includes, virtual / online contact with patients, then in principle other ICBs should accept and pay for virtual / online NCA in that service.

But virtual / online services should only be provided where it can be done safely and effectively. So – as we describe in paragraph 36.5 above – it's important that commissioners make clear, in contracts for choice services, whether the service, or any specific elements of it, may / must / may not / must not be provided on a physical "in person" basis or on a "remote" basis (by telephone or virtually / online). That way, NCA commissioners can be clear what should and what should not be available to choice patients on a virtual / online basis under that qualifying contract.

5) Providers' sites / locations

Question 18

My ICB has received an invoice for NCA carried out at a site in my ICB from a provider of elective surgical services with multiple sites nationwide. We don't hold a contract of our own with the provider. The provider has supplied a qualifying contract with another ICB 200 miles away – and the qualifying contract lists the site in my ICB's patch as one at which the provider can treat the host ICB's patients. What should I do?

This really shouldn't be happening. The ICB with the written contract with this provider is commissioning services for its population. These are not virtual / online services, and the chances of the ICB's patients choosing to travel for treatment to a location 200 miles distant are very limited. The ICB is unlikely to know anything about, let alone to have quality-assured, the provider's distant site.

ICBs should generally not list distant sites, at which they do not expect their own patients to be treated, in their contracts in this way, nor should providers ask them to. As we describe in paragraph 36.5 above – ICBs should:

- in terms of locations for physical "in person" service delivery, only list specific locations which you have commissioned to meet the needs of your local population and which you have satisfied yourself, through your usual assurance process, are suitable for the provision of high-quality and effective services; and

- avoid giving blanket approvals for other locations, outside your local area, including locations to be used by any sub-contractors employed by the provider.

In the short term, because the site is listed in the qualifying contract, the provider is able to carry out NCA on that site – and the ICB must pay for it.

But in the medium term, the NCA ICB should:

- raise the issue with the host ICB, so that its contract with the provider can be amended at the earliest opportunity so that it only lists relevant sites at which the host ICB expects its patients to be treated; and

- make clear to the provider that, if it wishes to provide choice services from its site in the NCA ICB's patch, it can approach the ICB at any time, under patient choice guidance, and ask to be qualified and, if successful, awarded a direct contract.

6) Providers' sub-contracts

Question 19

My ICB has received an NCA invoice from a new provider. The invoice is for activity undertaken by a sub-contractor on the provider's behalf. We have seen the provider's qualifying contract, and it does list this specific sub-contract in Schedule 5B (Provider's Material Sub-Contracts). Is this legitimate NCA which we should pay for?

The terms of the qualifying contract apply to any NCA the provider undertakes, but the qualifying contract is not the contract under which the NCA occurs. This means that, if the provider wishes to sub-contract any of its obligations in respect of NCA, it must – under GC12 – have the approval of the NCA ICB before doing so. Approval by the host ICB under the qualifying contract does not carry across to the separate contract on the same terms which is implied between the provider and the NCA ICB.

So what is or is not included in Schedule 5B of the qualifying contract is in fact irrelevant. The provider must seek approval in advance, from each affected NCA ICB, for any sub-contracting arrangement which affects that ICB's patients. If it does not do so, the NCA ICB will be entitled not to pay for any activity which has been carried out by the sub-contractor on behalf of the provider.

An NCA ICB may, if it chooses, take reassurance from the fact that the host ICB has approved the use of particular sub-contractors and may thus grant its own approval without delay. But that is at the NCA ICB's discretion, and the provider must not simply assume that the NCA ICB's consent to sub-contracting arrangements can be taken for granted.

Question 20

My ICB has received an invoice for a choice service direct from provider A. Provider A says it is acting as a sub-contractor to provider B. My ICB doesn't hold a contract with provider A, but knows that provider B has a qualifying contract entitling it to provide that choice service on an NCA basis. Should my ICB pay the invoice from provider A?

No. There is no direct relationship between a provider's sub-contractor and the provider's commissioner. Provider A must invoice provider B, which in turn must invoice your ICB. But remember that, as described in question 18 above, provider A

must have the NCA ICB's approval, in advance, for any sub-contracting it wishes to undertake.

7) ICB Prior Approval Schemes

Question 21

My ICB has received an NCA invoice from a new provider. The invoice is for outpatient assessment by a consultant, followed by inpatient treatment. But the inpatient treatment is for a procedure my ICB only commissions in very restricted circumstances, and the patient in this case does not meet my ICB's clinical criteria to receive this treatment, which my ICB has notified to the provider through a Prior Approval Scheme under SC29. Should I pay the invoice?

Individual ICBs quite properly make their own decisions about their detailed local commissioning policies and may have different approaches to whether (or on what basis) they commission specific treatments for their patients. The clinical criteria which one ICB applies to allow access to a commissioned treatment may be different to those applied by another ICB. This can cause difficulties with NCA, because an NCA provider will not automatically know, or have easy access to, the local commissioning policies of each ICB from which it may receive NCA referrals. So some pragmatism is needed in handling these sorts of situations. Our recommendations are below.

- The ICB should not pay for the treatment if it is listed as an intervention which should not be commissioned or provided under national Evidence-Based Interventions Guidance. SC29.24 of the Contract sets clear requirements of all providers in this respect.
- Otherwise, the ICB should accept that – in this first instance – the provider has accepted the referral and provided the treatment in good faith, and so the ICB should therefore pay the invoice.
- However, the ICB should at the same time formally notify the provider of its relevant local commissioning policies. These are what the Contract calls "Prior Approval Schemes" (PASs), which the ICB can notify to providers at any point under SC29.20. Once the one-month notice period for new PASs in SC29.20 has passed, the provider must then implement those PASs in relation to any further patients it is referred from that ICB – and the ICB need not pay the provider if it subsequently provides treatments which are contrary to any PASs which the ICB has properly notified.
- The ICB may also wish to continue its efforts to make sure that its GPs understand its local commissioning policies and do not refer patients specifically with a view to receiving treatments which the ICB does not commission.
- Remember, however, that SC29.19 (SC29.10 in the shorter-form Contract) makes clear that providers must not operate contrary to Patient Choice Legislation and Guidance.

8) Shared care

Question 22

Our ICB has received an NCA invoice. We have seen the qualifying contract and are satisfied that the service is a choice service. However, we see that the qualifying contract assumes that the provider will implement a shared care model with the host ICB's GPs, and payment to the provider under the qualifying contract works on that basis. We in our ICB don't have a shared care protocol in place with our GPs for this service. What payment terms will apply to NCA in this situation?

This is a good example of why it's better, for both parties, to move from NCA to a proper written contract as soon as possible.

Let's assume in this case that the qualifying contract works on the basis that the provider will provide assessment and diagnosis, then prescribe medication where appropriate, keeping the patient under review for the first six months, before transferring the patient to GP shared care, where the GP accepts that transfer. From that point onwards, the provider will only undertake an annual review. The standard prices to be paid under the qualifying contract reflect this.

In the NCA ICB, that move to shared care is not currently an option. So, in relation to NCA, the provider won't be able to move patients on to shared care and will incur additional cost from needing to undertake more frequent ongoing reviews and because it is doing the ongoing prescribing. The standard prices in the qualifying contract don't reflect these higher costs.

How can this be dealt with?

- First, it would probably have been sensible for the host ICB and the provider to have agreed alternative prices, included in the qualifying contract, to apply where a transfer to shared care is not possible. A GP cannot after all be forced to accept a transfer to shared care (see SC11.4). One possibility is therefore that the host ICB and the provider quickly agree some appropriate prices to apply in this situation and vary the qualifying contract to include them.

- Failing that, in the short term, the provider will need to contact the NCA ICB, explain the situation and propose a price it feels would be reasonable. It should really do this before the situation arises, rather than at the point where it needs to send an invoice. The two NCA parties can then discuss the issue, reach an appropriate agreement and note it for future reference.

- Moving to a direct contract for the next contract year, rather than remaining on NCA, will allow prices to be recorded properly.

- At the same time, the NCA ICB may want to consider whether it should look to extend its shared care arrangements with its local GPs in this particular service area.

9) Interface or referral assessment services

Question 23

My ICB has received an invoice from a new NCA provider. The service is a choice service, and we have seen the qualifying contract. However, the provider has accepted a referral into the service direct from one of our GPs – but my ICB operates an interface service which screens all GP referrals into this service and then, for those which genuinely require onward referral to secondary care, ensures that the patient is offered choice of (commissioned and NCA) providers at that point. Should my ICB pay the invoice?

In this first instance, yes, you should pay the invoice. The provider has acted in good faith in accepting the referral and providing treatment – it had no way of knowing about the interface service your ICB has put in place.

Ensuring proper use of the interface service is primarily a matter between the ICB and its GPs – so, for the future, your ICB may want to do more to promote awareness of the interface service among GPs.

10) e-Referral Service

Question 24

My ICB has received an invoice from a new NCA provider. However, we have confirmed that the service is not a choice service. We have therefore told the provider that we do not intend to pay the invoice. The problem is that the provider has listed its service incorrectly within e-RS, meaning that it is wrongly available to GPs from all ICBs. What should we do about this?

SC6.10 requires that, where the provider is listing a service on e-RS, it must do so correctly – with "choice" services available to all GPs nationwide and other locally-commissioned services available only to GPs of the specific ICB or ICBs which have deliberately commissioned that service.

So the provider must put this right immediately – otherwise it is misrepresenting the status of its services to GPs.

Your ICB should inform the provider at once and instruct it to change the e-RS listing in order to comply with SC6.10. You may also want to talk to the ICB which commissions this service locally from the provider.

Question 25

My ICB has received an invoice from a new NCA provider. We have reviewed the qualifying contract, and we have confirmed that the service is a choice service. The qualifying contract is held by a distant ICB, and the service is being provided largely virtually / online. We are concerned that the way the provider has listed the virtual / online service on e-RS is misleading. The service is listed as being physically located in our ICB, which means that – because e-RS promotes choice options on the basis of geographical proximity – it appears as a prominent choice option for GPs and patients in our ICB, but not for those in the host ICB which has actually commissioned the service. What can we do about this?

This is not straightforward, because e-RS requires each service to be associated to a physical location, even if the service is provided virtually / online.

In this instance, you should talk to the provider about why it is listing the service as being physically located in your patch. Unless there is a specific reason why this is appropriate, you should ask the provider to amend the e-RS listing, so that the location given for the virtual / online service is in the area of the host ICB (for example, the location of the commissioning ICB's headquarters can be used as a proxy in e-RS, for example). That way, the service will appear correctly on e-RS as a prominent choice option in the area covered by the ICB which has actually commissioned it for its patients – and that is a much more appropriate and less misleading outcome than if it is listed as being physically located in your ICB.

11) Ensuring informed choice

Question 26

My ICB has started seeing NCA referrals into a new provider. The service is a choice service, and we have checked the qualifying contract. The provider is based some distance away from our patch. It provides outpatient assessment on a virtual / online basis, but some patients may then need to attend in person for diagnostic tests and treatment. We are now noticing that, after the initial outpatient contact, a significant proportion of patients are asking to be referred back into our local services for treatment, because they don't want to travel. How should we handle this?

The expectation under choice is – generally – that patients will choose their provider for outpatient assessment and any subsequent treatment that may be required and has been specified in its host contract. So the norm is that a patient will remain under the care of their chosen provider unless the diagnosis changes significantly or there are other clinical reasons to change provider. Patients cannot expect to receive treatment that may be required but has not been specified in the host contract.

Patients may need to move between providers to some extent – but where a large volume of patients are selecting one provider, but then asking to be moved to a different one, it may be a sign that GPs and patients don't always have the right information on which to make an informed choice of provider.

So what should happen?

- Where patients wish and where clinically appropriate, the NCA provider should in principle refer patients on to other local providers for treatment in line with SC8.4. (Where the likely treatment is directly related to the reason for the initial referral,

patients don't need to be referred back to the GP – that just creates extra burden for primary care.) However, before this can happen on a safe and effective basis, it is likely that there will need to be discussions between the provider, the NCA ICB and that ICB's other local providers – this will be necessary to ensure that onward referrals can be made in accordance with agreed local referral pathways and criteria and so that local providers know that referrals from the NCA provider are legitimate and should be accepted. Where onward referrals of this kind are made and accepted, the receiving provider should then manage them in accordance with Referral To Treatment Rules.

- You should discuss with the NCA provider the information it is making available about its services, both on e-RS and on its website – to make sure that clear information is being presented to patients about where travel to the provider's sites will and will not be necessary and the service a patient can expect to receive from it.

- You should engage with your GPs, explaining to them the issues which are arising in relation to some referrals to this provider and urging them to make sure that patients choosing this provider know that – although outpatient assessment may be done virtually / online – they will be likely to have to travel for any actual treatment and potentially be referred to another provider requiring patients to join the new provider's waiting list. GPs will want to ensure that the provider and service they are offering is truly "clinically appropriate" for the patient in question.

Question 27

A neighbouring ICB holds a qualifying contract with a provider which delivers choice services from a location very close to the border with our ICB. Very few NCA referrals have been made to this provider by our GPs, however, and the provider has complained to our ICB that we are not offering patient choice "properly". Could there be any contractual justification for the provider's complaint?

Each ICB has a statutory duty to publicise and promote information about choice. Patient Choice Guidance describes different things commissioners can do to meet this obligation.

But an NCA provider is not entitled, contractually or otherwise, to receive a specific volume of choice referrals or a specific level of aggregate payment. So as long as the ICB is abiding by its "publicise and promote" duty above – and is not, through any messaging to GPs or patients, advising against referral to this particular provider – then the ICB is likely to be acting appropriately, and the provider would have no argument against it.

But an ICB may sometimes identify an apparently perverse pattern of choice referrals. Some "overloaded" providers with long waiting lists may still be receiving large volumes of new non-urgent referrals, while other equally accessible and high-quality providers of the same service may receive fewer referrals and have much shorter waits. In this sort of situation, the ICB may reasonably decide to work with local GPs to raise awareness of the way in which waiting times vary between providers – as a way of ensuring that patients are offered an appropriately-informed choice of providers.

12) Contract management processes

Question 28

My ICB is in an NCA relationship with a provider under which a significant volume of choice activity is being carried out. We are keen to ensure we understand as much as we can about the quality of care our patients are receiving at the provider. We have therefore asked the provider to supply to our ICB a Service Quality Performance Report, as required under Schedule 6A of its qualifying contract. Must the provider comply with this request?

Yes. As the regulations make clear, the terms of the qualifying contract with one ICB apply to the provision of the choice service to any patient referred from another ICB – so the provider must supply a Service Quality Performance Report to any NCA ICB which asks for one, just as it must supply one to its host ICB. The same applies for any other reports under Schedule 6A, whether nationally- or locally-specified.

Question 29

My ICB is in an NCA relationship with a provider. We have recently become aware, via patients and GPs, of some very significant concerns about the quality of the provider's services. We have asked the provider to attend an urgent Review meeting under GC8.4, to discuss the issues. Must the provider comply with this request?

Yes. Obligations under the Review and Contract Management provisions in GC8-9 apply equally in NCA relationships as in the provider's relationship with its host ICB.

If you have serious concerns about the quality of an NCA provider's services, you should also discuss these with the host ICB, raise them at the relevant System Quality Group and consider escalating your concerns in accordance with National Guidance on Quality Risk Response and Escalation in Integrated Care Systems. You may wish to alert the Care Quality Commission.

Question 30

Building on Question 28 above, our concerns about the quality of the provider's services have become more serious. We now believe that the provider is in "persistent or repetitive breach of the Quality Requirements" – which, under GC17.10, is grounds for immediate termination of the contract for provider default. Can our ICB terminate our implied contract with the provider?

This should be an extremely rare situation. It is probably not helpful for the NCA to think of terminating its own implied contract in isolation – but instead for urgent and concerted action to be taken across commissioners collectively. Having gathered the necessary information, the commissioners (host ICB and NCA ICBs with material values) must discuss the issue together and agree whether the situation is serious enough to mean that immediate termination of the provider's qualifying contact, by the host ICB, is a) the most appropriate step in clinical and service terms and b) contractually justified. Depending on the outcome of those discussions, the host ICB may then issue notice to terminate the qualifying contract with immediate effect. All parties will need to agree appropriate arrangements for managing patients in mid-pathway and those referred who have not yet commenced treatment. Clear, jointly-owned communications with patients and GPs will be essential.

In theory, a provider which has had its contract terminated in this way could simply apply immediately to any ICB to have its choice services qualified and to be awarded a new contract. But, in the short- and medium-term, that ICB would be likely to withhold its approval for a new contract, on the basis that the provider was not able to satisfy one of the qualifying criteria set out in the regulations – because its recent performance had demonstrated that it was not capable of complying satisfactorily with the terms and conditions of the NHS Standard Contract.

Question 31

My ICB is in an NCA relationship with a provider under which a significant volume of choice activity is being carried out. We have recently become concerned that the provider has made a local change in how its counts and codes Activity, without prior notification as required under SC28.11. We believe that the provider is making a material short-term financial gain from this change – whereas SC28.14 requires that the financial impact of any change must be rendered neutral during the first financial year. Is my ICB entitled to the protection of the provisions of SC28 in relation to counting and coding changes made by an NCA provider?

Yes, it is. The provider and each NCA ICB will need to comply with the requirements of SC28.6-15 in relation to changes in counting and coding practice. It will not be sufficient for the provider simply to inform its host ICB of a proposed change of practice under SC28.11, for example – it must also inform affected NCA ICBs separately.

Counting and coding changes are a complex area and are dealt with in detail at paragraph 44 above.

13) Differential treatment of referrals

Question 32

Our ICB is in an NCA relationship with a provider. The service involved is a choice service, and we have seen the qualifying contract. The provider is continuing to accept referrals from our GPs, but our patients are now having to wait a very long time for treatment. When we have queried this, the provider has told us that it is prioritising treatment for routine patients referred from the host ICB under the qualifying contract, rather than routine NCA patients. What can we do about this?

What the provider is doing is not clinically appropriate or contractually legitimate.

The provider is obliged to provide any NCA to the same service specification and quality standards as any activity for its host ICB. It is similarly obliged to provide services in accordance with Good Practice and to have regard to the NHS Constitution in respect of patients from all ICBs. It is not acceptable for the provider to discriminate against one set of patients and in favour of another, where the two sets of patients have broadly the same needs and clinical urgency. The provider should manage its waiting list using the prioritisation categories set out in national guidance – but should aim to treat patients from the same priority category broadly in date order by length of wait, regardless of patients' responsible ICB.

You should raise the issue with both the provider and the host ICB, requesting that the provider changes its approach. If that is not successful, you should issue the provider with a Contract Performance Notice and pursue the GC9 contract management process under your implied contract.

Question 33

Our ICB is in an NCA relationship with a provider. The service involved is a choice service, and we have seen the qualifying contract. The provider has now told us that it has ceased to accept NCA referrals in order to be able to prioritise capacity for patients referred from the host ICB under the qualifying contract. Is this acceptable?

No, it is not acceptable.

We cover this issue in paragraph 25.20 above, saying specifically "It is therefore not acceptable (and is a breach of contract) for a provider, with or without the support of its main local commissioners, to adopt a systematic policy of rejecting "choice" referrals or emergency presentations from distant ICBs (including those operating on an NCA or LVA basis), whilst continuing to accept those from within its local area".

You should raise the issue with both the provider and the host ICB, requesting that the provider changes its approach. If that is not successful, you should issue the provider with a Contract Performance Notice and pursue the GC9 contract management process.

Question 34

My ICB has received an NCA invoice from a new provider of cataract services. We already have contractual arrangements (some under written contracts, some under NCA) with multiple providers of such services, and our waiting times for these services are now very low. Can we simply say that we don't need any more providers of cataract services and decline to pay the provider's invoice?

No, you can't. If the provider has a qualifying contract, and if NCA referrals are made to it and it provides assessment and treatment in accordance with the agreed specification, an ICB must then pay the provider for that activity. However, it should be noted that the Contract Activity Management provisions apply to NCA activity and if an NCA provider is carrying out a significant volume of activity, an ICB might want to consider agreeing or setting an Indicative Activity Plan with the provider.

Question 35

Building on Question 34, my ICB has noted that our providers of cataract services (both those with written contracts and those operating under NCA) now all have very short waiting times – much shorter than for our other acute services. Can we, as a short-term measure to help control ICB expenditure, require our providers to slow down the rate at which they treat cataract patients?

If a provider is doing unnecessary or clinically inappropriate activity (i.e. activity not in accordance with the relevant service specification), an ICB can certainly intervene. But otherwise, once patients have been referred, the provider must provide necessary and appropriate treatment or care, generally in a way which meets national and local standards for quality and waiting times (SC1.1 and 3.1).

An ICB (including where acting under NCA) can use the provisions of SC29 (Managing Activity and Referrals):

- It can apply its own Prior Approval Schemes, ensuring that access to treatment at the NCA provider is in accordance with the NCA ICB's commissioning policies.
- It can require an Activity Management Plan (or Remedial Action Plan) if the provider is doing excess activity by breaching the service specification or if the provider has breached an agreed or set Indicative Activity Plan.

Under NCA, an Indicative Activity Plan could also still be agreed or set for the provider and the ICB could then use the Activity Management provisions to manage activity with the provider. An ICB can also consider controlling the actual volume of activity across its "choice" providers (under written contract or NCA) by clinically appropriate management of referrals from primary care, as long as patient choice is still offered appropriately. Where significant contract management of a provider is required, we would always recommending agreeing a written contract if possible.

14) Moving away from NCA arrangements

Question 36

My ICB has been in an NCA relationship with a provider for several years. The value of our choice activity at the provider is now significant – over £1m per year. We are not satisfied from a governance perspective with continuing to rely on NCA arrangements, and we want to enter into a direct contract with the provider for next year, to be awarded under direct award process B of the NHS Provider Selection Regime. Is the provider obliged to accept a direct contract award, or can it continue instead to operate on an NCA basis?

The regulations state that a provider can at any time approach an ICB to be qualified for the provision of choice services – and, if successful, awarded a direct contract by the ICB. But the regulations also mean that a provider can, instead, continue to rely on NCA arrangements if it chooses – on the basis of a qualifying contract with at least one ICB. This is not the approach we would recommend (see paragraphs 25.8-9 above), but it is something which providers can nonetheless decide to do.

See also our answer to Question 37 below, which describes how ICBs can work together to put in place joint commissioning arrangements under single joint contracts.

Question 37

My ICB has been in an NCA relationship with a provider for several years. The qualifying contract is held by our neighbouring ICB, and we are not satisfied that it is robust, in respect of either the specification or the local quality standards. So we want to enter into our own direct contract with the provider for next year, to be awarded under direct award process B of the NHS Provider Selection Regime. Is the provider obliged to accept a direct contract award from my ICB, or can it continue instead to operate with us on an NCA basis?

The provider is not obliged to accept a direct contract award and can continue to operate on an NCA basis for as long as it holds a qualifying contract.

However, ICBs should bear in mind that all contracts have fixed terms and that, with notice, they can be terminated early on a “no fault” basis (see GC17).

So your ICB may wish to talk to the neighbouring ICB – and other local ICBs – about taking a joint approach, in future, to awarding and managing contracts for some or all choice services. This is the norm for contracts with Trusts, after all. To do this, the ICBs will need to agree on standard requirements – a common specification and quality standards, the same approach to local prices – and they will need to identify one of their number to act as co-ordinating commissioner. But a joint commissioning arrangement of this kind will be likely to be more effective and efficient for both the ICBs and the provider.

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