NHS Standard Contract 2025/26 consultation

Final response submitted via online survey - NHS Standard Contract 2025/26: A consultation - NHS England - Citizen Space

National quality requirements

		Support proposal?			Comments
		Yes	No	NA	
6)	Zero tolerance RTT waits over 78 weeks for incomplete pathways	X			
7)	Percentage of RTT waits over 52 weeks for incomplete pathways	X			We agree that this aligns with the Planning Guidance commitment to reduce the proportion of people waiting over 52 weeks.
8)	Cancer waits (28 days and 62 weeks)	X			

Additions and updates to reflect national priorities and guidance

		Support proposal?			Comments
		Yes	No	NA	
9)	Leadership competency and appraisal frameworks for board members			X	On the basis that this only applies to Trusts, we have no objection to the proposal.
10)	Culture of care standards for mental health inpatient services			X	

Patient safety

		Support proposal?			Comments
		Yes	No	NA	
11)	Patient Safety Partners			X	We note that SC33.10 only applies to NHS Trusts and Foundation Trusts. We therefore have no objection to this material change.
12)	Child Protection Information Sharing Service (CP-IS)			X	

Medicines

		Support proposal?			Comments
		Yes	No	NA	
13)	Medicines optimisation			X	
14)	Controlled Drugs Accountable Officers			X	

Workforce

		Support proposal?			Comments
		Yes	No	NA	
15)	Staff attendance and retention			X	
16)	NHS Sexual Misconduct Policy and Guidance			X	
17)	Improving the working lives of resident doctors			X	

Procurement, estates and Green NHS issues

		Support proposal?			Comments
		Yes	No	NA	
18)	Energy purchasing			X	We note SC18.4 states that it applies to "All", but the specific wording is explicitly about NHS Trusts or NHS Foundation Trusts. Given the size and purchasing power of such entities, it is a strategic decision for the NHS to decide if this will strike the right balance between cost control today and environmental impacts in the future. This however should not be extended to smaller providers (non-NHS Trusts/FTs) without further consultation.
19)	Modern slavery			X	Given SC39.1 makes clear that SC39.9 only applies to NHS Trusts and Foundation Trusts, we have no objection to this material change.
20)	NHS Estates Guidance			X	
21)	Green NHS issues	X			On the basis SC18.4 does not apply to all providers, we do not object to the minor changes made to SC18.3.

Referral arrangements and patient choice of provider

		Support proposal?			Comments
		Yes	No	NA	
22)	Appropriate listing of services on e-RS	X			
23)	Terms under which non-contract activity (NCA) is undertaken	X			We agree with aligning wording with the new patient choice regulations.

24)	Sharing by providers of "qualifying contracts"			X	
25)	UEC Booking and Referral Standard			X	
26)	Onward referral	X			While this makes sense and should in theory reduce pressure on GPs and help patients access the right care pathway sooner, it is not clear this has been widely socialised and therefore patients may continue to be referred back to their GP when this is unnecessary. It might therefore be beneficial to add more examples to the Technical Guidance to support providers-ICBs in having a constructive dialogue with providers to implement such changes. (Please also see our response to the NHSPS below, because if ICBs do in fact enforce the proposed payment limits, but demand providers see additional patients without funding, then SC8.4 risks becoming a theoretical concept).

2025/26 NHS Payment Scheme

		Support proposal?			Comments
		Yes	No	NA	
27)	Payment for Services Paid for on an Activity Basis		X		While we appreciate that the NHS Standard Contract team has read across draft proposals from the NHSPS 2025/26 consultation, in our view these conflict with, and hence should have been superseded by, the objectives set out in the latest NHS mandate and with government's stated aims for the NHS. As designed, these proposals would have a serious and retrograde impact on patient choice – e.g. reduce incentives for providers to improve services, which was one of the reasons patient choice was enshrined in the NHS Constitution. Given the significant potential impacts, in our view, the NHS Standard Contract team should undertake its own more wide-ranging impact assessment before making such a major change to the contract –

					this impact assessment should be more comprehensive than the impact assessment the pricing team has undertaken e.g. as that excludes any reasonable attempt to understand the impact on people with disabilities. We would also ask the NHS Standard Contract team to review this proposal in the context of the Public Sector Equality Duty (PSED), because without further work on the impact of effectively capping activity, there is a risk that services accessed by patients with disabilities (e.g. hearing loss services) are more likely to face implicit/explicit rationing than more 'newsworthy'/politically sensitive' services. The checks and balances in place to mitigate this risk are very limited and will not protect these vulnerable groups of patients. This all appears to arise from an over-hasty and un-thought-through pricing proposal. To give but one example: for many years NHS England has known that indicative activity plans (IAPs) have simply been based on previous years' activity or 'finger-in-the- air' assumptions about local need/demand. Consequently, if providers have delivered above IAPs, commissioners have challenged these in terms of "over performance" without being able to explain how they derived the IAP and of their assumptions about expected activity devoid of evidence. Put simply, "over performance" is more often a consequence of commissioners guessing/downplaying what future activity might be without any assessment of actual need. Left unchallenged, heavy-handed enforcement of such weak IAPs would have put services and therefore patients at risk. Fortunately for patients, providers have been able to support/ challenge commissioners as needed to ensure access to care is not prematurely curtailed based on defective IAPs estimates.

					Focusing on these issues have also been a key driver in highlighting other operational inefficiencies – e.g. hidden block contracts which could in fact be cut/reformed and scarce NHS funds released and repurposed to fund care in a more transparent way. The current proposals risk removing these checks and balances based on an overly simplistic total cost control approach without regard for the real world of patient access/outcomes. While we fully support the need for the NHS to control total costs, it must be based on NHS England and ICBs fulfilling their public safety functions first. For example, for many years both NHS England and ICBs have known that adult audiology services can be delivered out of hospital for less cost (based on the NHS's own evidence) but have placed themselves in the Catch 22 position of failing to deliver reform to free up resources whilst arguing that the NHS cannot meet more hearing needs because "difficult decisions" need to be made about scarce NHS resources. NHSPS and Standard Contract proposals as they stand, will risk supporting/legitimising this 'Old Think' at a significant cost to patients, the NHS and taxpayer.

Further comments

28)	We have serious concerns about the way in which the NHSPS for 2025/25 plans to use pricing and caps on contracts as a blunt tool to control total costs without thinking through the disbenefits and adverse consequences for patients and government policy. Such an approach will risk undermining the system levers to deliver the government's three shifts for the NHS. We would ask NHS England to undertake a more detailed impact assessment before making the significant changes proposed, to ensure it has fully considered its PSED and that Ministers are fully aware of the significant braking effect this is likely to have on service transformation and the government's plans to rebalance the NHS in the NHS 10 Year Health Plan.