Royal College of Nursing response to Proposed changes to the NHS Standard Contract for 2025/26

With a membership of over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital, mental health and community settings in the NHS and the independent sector. The RCN promotes priorities for nursing and patient safety, works closely with wider professional bodies and trade unions, and lobbies governments and other bodies across the UK to develop, influence and implement policy that improves the quality of patient care.

The RCN welcomes the opportunity to propose changes to the provisions set out in the draft NHS Standard Contract for 2025/26. Given the NHS Standard Contract's key role in outlining standards of care and setting aspects of performance standards for providers, the RCN sees this consultation as an opportunity to ensure that the NHS can meet population health needs and provide care at a high standard.

For example, introducing mandatory reporting on care in inappropriate non-clinical settings would play a strong role in ensuring that this does not become normalised. Similarly introducing new conditions for staff, such as the provision of free car parking, would help to ease the burden on nursing staff who have received years of below-inflation pay rises.

The Standard Contract is currently used to promote good practice in quality and safety for patients and staff, a particularly important lever in the context of the long-term transformation needed via the 10-year plan for the NHS.

We set out here our proposals for additional requirements to include in the standard contract on issues in need of greater transparency and focus.

Mandatory data reporting

'Corridor care' data

The NHS Standard Contract should support with data collection on the issue of 'corridor care'. The term 'corridor care' refers to the practice of providing care to patients or residents in corridors or other non-designated areas. It is a complex issue but key causes include overwhelming demand and a lack of available appropriate space and shortages of resources, including staff.

The RCN, along with a coalition of professional and patient organisations, is calling for corridor care to be eradicated due to its significant consequences for patient safety and dignity and the negative impacts on patient care and on nursing and other health and care staff. This can also lead to delays in treatment, increased risk of infections, and increases the stress on nursing staff to work in inadequate and unsafe spaces.

Data collection is an important first step in recognising the true scale of the issue and can form the basis for targeted local and national intervention.

The RCN calls for service providers who hold publicly funded contracts to collect and publish provider-level data about every instance in which care has been delivered in a non-clinical setting or temporary escalation area, even if the same setting is being used regularly. This should be mandated within the NHS Standard Contract.

Service commissioners should mandate reporting on instances of corridor care (treatment of patients in hospital corridors, cupboards and other unsuitable spaces), which will be collated centrally by NHS England and published by the government on a regular basis. Below is an outline of the detailed requirements that should be included in the collection.

The collection of this data will allow both service commissioners and national decision makers to identify trends, solutions and mitigate risks to patient safety. This will help make progress towards eradicating the practice.

When trends indicate that capacity is regularly above the planned and funded levels, commissioners should work with service providers to find ways in which the pressures contributing to corridor care are addressed.

*Our detailed requirements for reporting on corridor care are:

Coverage

- All service providers who hold publicly funded contracts should be required to collect data about every instance in which care has been delivered in a non-clinical setting, or temporary escalation area, even if the same setting is being used regularly.

Demographics (of the patient involved)

- Age, gender, ethnicity, disability and any other protected characteristics including homelessness

Instances (data per instance)

- All instances of care being delivered in an area which was not originally designated as a clinical space (including and noting both temporary escalation spaces and other areas) and what type of non-clinical area was used (car park, chair, corridor, additional patient in a ward bay or other options)
- Recording the OPEL level when temporary escalation spaces are used
- Numbers of people who are not in beds [those counted within the bed occupancy data set], and the time they have spent in a temporary-escalated bed/chair/trolley/other
- Numbers of escalated beds/trolleys/chairs and how long they are open for
- The reason (per instance) as to why care was delivered in this way.
- Information about staffing levels (per role) when the corridor care occurred (sickness and absences, turnover, vacancy rates, use of agency staff, protected characteristics of staff involved etc)
- How far the call bell is from patient i.e. how does patient call for help or how we spot early signs of deterioration if patient not on telemetry?
- The acuity/frailty of the patient affected [using the clinical frailty score, NEWS2 etc]

Impact (data per instance)

- What the impact on care was for the patient involved [missed care interventions, lack of access to privacy or dignity, no call bell, lack of comfort, gender breach, preventable or unexpected harm or preventable or unexpected death etc]
- What the impact on care was for the staff member [care left undone, missed breaks, lone working, stress, extra unpaid hours, unable to give other patients dedicated time, delays to logging incidents etc]
- Any related patient safety incident reporting
- Any related staff safety incident reporting
- Confirmation that corridor care instances have been added to relevant medical notes, risk assessments and risk factors. (This will help to identify trends with impacts at later stages for example pressure sores and increased mortality in the short to medium term.
- Medicine related incidents [delays to medicine reaching patient (could be as the unassigned area has no set delivery point for medicines like a ward area), delay in receiving critical meds, wastage of meds and re-work e.g. lost due to transfers, redispensing required]

Time period data (per month)

- Number of deaths in corridors and other spaces not originally designated as a clinical space

- Workforce data reporting and transparency

The RCN calls for the standard contract to require providers to collect and report on workforce data and make this publicly available. This would support robust workforce planning throughout the system.

Currently, comprehensive nursing workforce data is not publicly available, and the data which is published has gaps in it. For example, there is no vacancy data available at provider level, which makes it impossible to know what the overall workforce gap is, and where the areas of highest vacancies are. Transparency is essential to identifying the areas with the highest risk of care being compromised due to a lack of staff. It will also enable greater scrutiny regarding the impact of national policy decisions.

This is also true of the independent sector, which is facing growing demand and a similar growing workforce crisis. Introducing a requirement for providers to report on workforce data in the independent sector where providers are delivering NHS-funded services would place a greater responsibility on providers to ensure that staffing levels are adequate and would help to better highlight issues such as regional variance in vacancies.

RCN workforce standards

The RCN calls for the NHS Standard Contract to require providers to adopt the RCN Nursing Workforce Standards in the design and delivery of their workforce plans, in all types of health and care settings.

The RCN Workforce Standards are a blueprint for tackling nursing staff shortages across the UK. They support the nursing workforce to be safe and effective. They set the standards for high quality, evidence-based patient/service user care in all health and care settings in the UK, working with each nation's legislation. Evidence and experience have shown that having the right number of nursing staff, with the right skills, in the right place, at the right time improves health outcomes, the quality of care delivered, and patient/service user safety.

The RCN Workforce Standards can be used:

- As a self-evaluation tool to identify training, learning and development needs by any member of the nursing workforce.
- To standardise what is offered to nursing workforce and departments by a manager, matron, or team leader.
- To give floor-to-board assurance that support interventions are available and accessible to all the nursing workforce by a nurse director.

- As a tool for all nurses, nursing support workers and students to use as a benchmark for their workplace
- As a reminder of the legal requirements to ensure the health, safety and welfare of the nursing workforce

International recruitment

The RCN calls for the NHS Standard Contract to require providers to adopt and act in accordance with DHSC's code of practice for international recruitment of health and social care personnel.

When conducting international recruitment it is essential that all employers and recruiting agencies are compliant with the code of practice for international recruitment of health and social care personnel. This includes avoiding active recruitment campaigns in countries identified as facing the most pressing health workforce related shortages which are identified on DHSC's 'red list'.

Another key area of the code of practice which employers must align to is best practice principles on the use of repayment clauses. The RCN is also concerned by reports from some internationally recruited members working in health and social care that their contracts contain excessive repayment clauses. In one particular case a member reported they had faced a £25,000 fee for leaving their contract earlier than the stated terms. In many cases members report that employers make attempts to intimidate them into paying these fees through threats of deportation and referrals to the NMC. Alongside the Code of Practice, NHS Employers guidance sets principles for best practice including; the need for transparency; proportionate costs with a maximum repayment amount; the need for fees to taper down with service; and for employers to have flexibility in waiving fees in certain circumstances.

Safe and affordable travel to work

The RCN believes that all staff should be able to access safe, sustainable, and affordable travel to work regardless of their role and working hours. The RCN expects all employers to enable their staff to travel to work sustainably without exposure to unnecessary cost and risk.

The NHS Standard Contract should include a requirement for employers and providers to review their travel policies to ensure staff can travel to work safely, sustainably and affordably, including the provision of free car parking for nursing staff where possible and the expansion of other sustainable travel options for staff.

The changes and our corresponding responses are set out below:

Zero tolerance RTT waits over 78 weeks for incomplete pathways Service Conditions Annex A (FL and SF)

Proposed change:
We have deleted the 78-week standard, as it has been superseded by the 'percentage of RTT waits over 65 weeks for incomplete pathways' standard.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN is supportive of this proposal as this aims to provide a more accurate measure of waiting times and help prioritise those with the longest waits.

Percentage of RTT waits over 52 weeks for incomplete pathways Service Conditions Annex A (FL and SF)

Proposed change:
We have added a 52 week wait RTT standard, in line with the Planning Guidance commitment to reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
The RCN is supportive of this proposal as this is a significant step towards improving patient and reducing the backlog.

Cancer waits (28 days and 62 weeks) Service Conditions Annex A (FL only)

Proposed change:
We have changed these standards from 77% to 80% and from 70% to 75% respectively, in line with the national priorities and success measures set out in the Planning Guidance.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
The RCN is supportive of this proposal as this change reflects a commitment to improving timely access to cancer diagnosis and treatment, ensuring better outcomes for patients.

Leadership competency and appraisal frameworks for board members Service Condition 1.4 (FL only) and Definitions

Proposed change:
For 2024/25, we added to the Contract a requirement for Trusts to comply with the Fit and Proper Person Test Framework for board members. NHS England has now published a new leadership competency framework for board members, including a framework for conducting annual appraisals of NHS chairs. We propose to expand the Contract requirement, so that Trusts must also adopt and apply the leadership competency and annual appraisal frameworks in their recruitment and appraisal processes.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Effective leadership is directly linked to patient safety, staff wellbeing and service quality, therefore strengthening the leadership and governance is incredibly important.

The FPPT ensures board members are meeting the basic legal requirements, it does not sufficiently assess leadership capability or ongoing competence, which would be supported through appraisal frameworks. Adopting annual competency and appraisal frameworks enables more structure, transparency and accountability when assessing board level leadership.

This approach embeds a culture of continuous improvement which ripples through the organisation and ultimately impacts on patient care. It also provides a mechanism for ensuring board members demonstrate positive leadership behaviours and also enables support to be provided if areas of development are identified.

Culture of care standards for mental health inpatient services Definitions (FL only)

Proposed change:
The Contract, at Service Condition 8.9, requires providers to have regard to Standards for Inpatient Mental Health Services, currently defined by reference solely to the Royal College of Psychiatrists standards. NHS England has published culture of care standards for mental health inpatient services, and we propose to broaden the Contract definition of Standards for Inpatient Mental Health Services so that it covers both sets of standards.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
We agree with extending the definition of Standards for Inpatient Mental Health Services to broaden the options available to providers. However, there must be clear governance and safety measures in place, as is for AIMS (RCPsych), to ensure high quality accreditation is offered by reputable sources.

Patient Safety Partners Service Condition 33.10 (FL only) and Definitions)

Proposed change:
NHS England's Framework for Involving Patients in Patient Safety* describes the role of Patient Safety Partners (PSPs). A PSP takes a role in a provider's safety governance (for example, sitting on relevant committees to support compliance monitoring) and in the development and implementation of relevant strategy and policy. We propose to include a new requirement for each NHS Trust and NHS Foundation Trust to identify two or more PSPs to fulfil the role described in the Framework.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN strongly advocates for patient safety and actively supports the concept of "Patient Safety Partners" (PSPs), which are individuals like patients, carers, or members of the public who contribute to a healthcare organisation's governance and management processes. The RCN recognises the importance of PSPs in identifying potential issues and improving patient safety practices within healthcare settings. Requiring there to be two or more PSPs for each Trust means there can be a voice given to patients in decision-making regarding their care and all Trusts can have equality in this role and in hearing valuable perspectives from the patient experience.

Child Protection Information Sharing Service (CP-IS) Service Condition 32.8 (FL only)

Proposed change:
CP-IS helps health and social care workers share information securely to better protect children and young people who are known to social care. CP-IS is mandated under an Information Standards Notice and has so far been used only in unscheduled care settings. There is a long-standing provision in the Contract

requiring relevant providers to work together to implement CP-IS effectively. An updated Information Standards Notice (DCB1609) has now been published, requiring extension of CP-IS use to certain scheduled care settings. The new settings relevant to this Contract are child and adolescent mental health services, sexual assault referral centres, termination of pregnancy services and community paediatrics. In this context, we propose to amend the existing CPIS provision to include:

- An explicit obligation on providers to ensure that relevant staff have access to and make appropriate use of CP-IS; and
- An expansion to the applicability of the CP-IS provisions in the Contract, so that they apply to providers of relevant scheduled care services, as well as in unscheduled care.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Sharing of information securely is integral to the safety and protection of children and young people who are known to social care. CP is firmly embedded within the core duties and statutory responsibilities of all organisations across the NHS and health system and sharing of information is key in these circumstances.

Medicines optimisation Service Condition 3.20 (FL only) and Definitions

Proposed change:
NHS England has published National Medicines Optimisation Priorities* for implementation across NHS systems. We propose to include a new requirement for each provider to use all reasonable endeavours to assist its commissioners in their implementation.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Medicines optimisation is a useful method of improving the prescribing practice within a service and should be encouraged. Even small medicines optimisation projects can significantly improve patient safety.

Controlled Drugs Accountable Officers Service Condition 33.12 (FL only) and Definitions

Proposed change:
We propose to include a requirement for all Trusts and all but the smallest non-NHS hospitals to appoint and support a Controlled Drugs Accountable Officer in accordance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
com
Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

This is a safety aspect of the control and monitoring of controlled drugs. There would need to be resources provided to ensure adequate training and release from the service for the CD accountable officer to be able to carry out their role competently and confidently. Controlled Drugs need to be managed and used effectively, not controlled so tightly that it is to the detriment of the patient.

Staff attendance and retention General Condition 5.9 (FL only) and Definitions

Proposed change:
We propose to include a new requirement on Trusts to promote high staff attendance and retention and to have regard to national guidance in these areas (NHS Employers' Sickness Absence Toolkit and Improving Staff Retention).

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Although we recognise that this contract relates to provider organisations, we note that they are limited in their ability to influence overall workforce supply and retention. Whilst it is valuable to promote high staff attendance and retention, it is vital for the Government to address the reasons why many are leaving the profession and why many must take sickness absence. This is often due to stress, burnout, lack of colleague support, workload and concern about quality of care for the public.

The Government, DHSC and NHSE have a responsibility to create supportive conditions within which providers can meet their contractual duties. Duties relating to workforce planning and retention will not be achievable without sufficient investment in the workforce based on an accurate assessment of patient and population need, which must be accompanied by a fully funded long term workforce plan by government. This is alongside fair pay for staff and options for career progression.

Trusts should also be monitoring presenteeism. Many nurses continue to work when unwell as they do not want to further burden their colleagues or because they are concerned about the repercussions of punitive absence management policies. Staff should be supported to take sickness absence when necessary and not be rushed back into the stressful conditions that may have caused the sickness absence initially.
All the above would ensure that the nursing workforce has the right numbers of staff in the right places, to ensure staffing for safe and effective care, reduce sickness absence and improve retention.

NHS Sexual Misconduct Policy and Guidance General Condition 5.9 (FL only) and Definitions

Proposed change:
We propose to include a new requirement on Trusts to have regard to the principles, and undertake the actions, set out in these recently published national documents:

- The Sexual Safety in Healthcare Charter
- National People Sexual Misconduct Policy Framework; and
- The Sexual Safety Charter Assurance Framework

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

We support these proposals. There is no place for sexual misconduct in the NHS and as well as tackling misconduct form staff, Trusts also need to address harassment from third parties including patients and service users and the public. Trusts should also have due regard to the legal duties under health and safety legislation to assess and reduce the risk of violence and harassment. This is particularly important when protecting nursing staff who work alone in the community.

Trust should work in partnership with their local trade unions and staff networks to develop policies that as a minimum follow the principles of the National People Sexual Misconduct Policy Framework. As stated in the framework, we would not want the national policy to override existing stronger polices on sexual misconduct.

Improving the working lives of resident doctors General Condition 5.9 (FL only) and Definitions

Proposed change:

We propose to include a new provision under which Trusts must implement the specific required actions set out in Improving the Working Lives of Resident Doctors.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Whilst we support this proposal and acknowledge that it vital to do better for resident doctors, and actions set out in reports must be implemented, improving the working lives of all NHS staff is a key strategic priority, as made clear in the NHS Long Term Workforce Plan. There is much more than can be done to improve the working and learning experience of nurses in the NHS too.

Nurses in postgraduate training can be impacted by shift allocation and should also have better rota management and deployment, as well as protected time to do mandatory training and learning.

The Improving working lives of resident doctors' publication also asks Trusts to ensure they are considering BMA wellbeing guidance. This aligns with some of the RCN's Nursing Workforce Standards. The RCN Nursing Workforce Standards is a tool to be used to support safe staffing levels across the UK. It supports the nursing workforce to be safe and effective and sets the standards for high quality, evidence-based patient/service user care in all health and care settings in the UK, working with each nation's legislation.

There are 4 standards on health, safety and wellbeing which outline the health, safety, dignity, equality and respect values of the nursing workforce to enable them to provide the highest quality of care.

NHS Estates Guidance Service Condition 17.1 (FL only) and Definitions

Proposed change:
The Contract contains specific requirements on Trusts relating to NHS estates issues – completion of the NHS Premises Assurance Model and compliance with HBN 00-08 are two examples. We propose to rationalise these into a single, broader requirement for each Trust to have due regard to, and where applicable comply with, "NHS Estates Guidance". We propose to define NHS Estates Guidance to include the following:

- health building notes;
- health technical memoranda;
- NHS Estates Technical Bulletins;
- NHS Premises Assurance Model; and
- the NHS Net Zero Building Standard,

all available at https://www.england.nhs.uk/estates/.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The NHS Premises Assurance Model supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services. NHS Estates Technical Bulletins enable updated guidance to be passed to local systems, ensuring a focus on patient safety is maintained.

Whilst adding this detail to NHS Estates Guidance provides more assurances that the estate is safe, efficient and of high quality, there is nothing here to help address the issue of corridor care, where nurses are delivering care in unsafe and overcrowded environments due to overwhelming pressures on the NHS. Commissioners of services should increase their scrutiny of where and how care is provided, putting safeguards into contracts that there is sufficient provision to meet demand. We call upon commissioning bodies to amend contracts for publicly funded services to include specific restrictions on using non-clinical spaces for the delivery of care, and requiring reporting if breaches occur.

Green NHS Service Condition 18.3 (FL only) and Definitions

Proposed change:
To clarify the requirements at SC18, minor amendments have been made to the scope of the requirements and to align them with best practice guidance.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The Royal College of Nursing is disappointed that the NHS Contract has not strengthened the requirements under SC18 given the benefits of achieving Net Zero bring to resilience in addition to reduced greenhouse gas emissions. A requirement to 'report on progress against Green Plan' should be amended to reflect the need to 'report and demonstrate progress' on meeting the Green Plan objectives.

Terms under which non-contract activity (NCA) is undertaken Service Condition 6.14 (FL) and 6.3 (SF)

Proposed change:
For many years, a provider which holds a contract with one commissioner for a service within scope of the patient choice regime has automatically become an available choice for referrals (into the same service and in the same location) of patients from other commissioners. The activity which the provider then undertakes for the other ICBs is generally referred to as non-contract activity (NCA). To date, in the absence of any clearer position in legislation, Service Condition 6.14 has stated that the implied terms of an NCA arrangement are to be determined based on the position set out in the section of our Contract Technical Guidance where we deal with NCA (paragraph 25). However, the new patient choice regulations in place since January 2024, state that the terms of the provider's "qualifying contract" (that is, the NHS Standard Contract which it holds with an ICB) apply to the NCA which the provider undertakes for the other ICBs. We therefore propose to amend Service Condition 6.14 to use the same language as the regulations in this respect. The Technical Guidance continues to give detailed advice about how the implied contractual terms under an NCA arrangement should be understood, and we have added an additional appendix (Appendix 4) dealing with common scenarios.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN is supportive of this proposal and we do not have any concerns.

UEC Booking and Referral Standard Service Condition 6.19 (FL only) and Definitions

Proposed change:
The Booking and Referral Standard (BaRS) is an interoperability standard which enables booking and referral information to be sent between providers quickly and safely. BaRS has initially been used in limited settings in urgent and emergency care (UEC). The Contract refers to BaRS in Service Condition 6, requiring providers of A+E services and Urgent Treatment Centres (UTCs) – when updating, developing or procuring relevant IT systems – to ensure that their updated / replacement systems enable direct electronic booking of attendance slots for patients.

BaRS is gradually being rolled out so that its use is required across more UEC pathways, now also involving 999, 111, Same Day Emergency Care and Clinical Assessment Services – either as bookers of appointments or as recipients of bookings. This coverage will extend further over time.

To reflect the roll-out of UEC BaRS, we propose to update the Contract wording in two ways:

- to broaden the wording so that it goes beyond the updating of IT systems and, once IT is in place, requires receiving providers to make slots available and referring providers to make electronic bookings.
- to broaden the service categories to which the BaRS provision applies, to cover emergency ambulance services, NHS 111, acute services and community services, as well as A+E and UTCs.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

In theory, BaRS would ensure UEC nurses (and MDT colleagues) receive the information they need, in a format they can use, integrated into their existing healthcare IT systems. It would do this both within UEC and between UEC and other parts of healthcare. This would undoubtedly improve efficiency and save nurses much needed time. It could improve the experience of both patients and nurses.

Onward referral Service Condition 8.4 (FL only)

Proposed change:
Arrangements for onward referral by providers have been covered in Service Condition 8 for many years, distinguishing carefully between situations where a provider's clinicians must make the onward referral themselves and where they should refer back to the GP for consideration of a possible further referral. We have identified a gap in the coverage of Service Condition 8. Where a patient who has been referred into one of a provider's services then requires non-immediate onward referral into another of the same provider's services and where the reason for the onward referral is directly related to the condition or complaint for which the original referral was made, the wording is clear that the provider's clinician must make the onward referral, rather than referring back to the GP. However, the wording has not directly addressed a situation where the onward referral which is needed is to the services of another provider. We propose a change to Service Condition 8.4 to remedy this. We cannot state an absolute obligation on a provider's clinician to make an onward referral to any service offered by any another provider – the legal right of choice of provider does not apply to onward referrals made by secondary care clinicians, and so the "other" provider must be one which the patient's ICB, as commissioner, is content is appropriate to be used. However, the important principle remains that such onward referrals should be made by the clinician in secondary care, rather than the patient being referred back to the GP. The revised wording we propose

therefore places the obligation on the provider, in co-operation with the relevant ICB, to secure the provision to the patient of the required treatment or care.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN support this however we believe that there should be discussion around patient choice, where possible the secondary care clinician should make onward referral rather than refer back to the GP.

Appendix 1: Smaller updates

Armed Forces Covenant Service Condition 1.5 (SF only)

Proposed change:
The full-length version of the Contract has for many years included a requirement on both commissioner and provider to have due regard to the Armed Forces Covenant and the Armed Forces Duty Statutory Guidance. We propose that this requirement should now also be included in the shorter-form version of the Contract.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Yes, it is important to abide by the Armed Forces Covenant to ensure we appropriately care for the people that have or who are currently serving and that they are not disadvantaged by having served. This requirement should therefore be included in the shorter-form version.

Working with and involving patients and others Service Condition 12.4-5 (FL only)

Proposed change:
Service Conditions 12.4-5 contain requirements on providers to engage and communicate with patients, carers, GPs, staff and the public, seeking their feedback and involving them in discussions about potential improvements to services. We propose to reorder this content slightly, introducing a requirement for relevant providers to have regard to statutory guidance on Working in Partnership with People and Communities

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

It is widely recognised that effective partnerships between the NHS, social care, local authorities, and other organisations can only foster better and more sustainable approaches when they are shaped by the needs, experiences, and aspirations of the communities they serve.

Reordering the content to ensure that relevant providers are fully aware of the statutory guidance will enhance communication and understanding of the necessity of involving patients and stakeholders in service improvements. The statutory guidance outlines ten key principles that providers should consider, offering a structured framework for meaningful engagement with patients and other stakeholders.

The RCN fully supports this proposal to embed patient involvement in service improvement and acknowledges the crucial role of the patient voice in driving higher standards of care.

NICE guidance on self-harm Service Condition 15.3 (FL only)

Proposed change:
In the context of patients under the age of 18 requiring urgent mental health assessment, care or treatment, the Contract includes a reference to NICE guideline CG16 (Self-harm in over 8s). CG16 has been replaced by NG225 (Self-harm: assessment, management and preventing recurrence), and we propose to update the Contract accordingly.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN is supportive of this proposal, as an update to evidence-base, and we do not have any concerns.

Covid-19 vaccination Service Condition 21.4 (FL only)

Proposed change:
The current Contract requires providers to use all reasonable endeavours to ensure that all eligible frontline staff are vaccinated against influenza and Covid-19, in accordance with JCVI guidance and the Green Book. Updated JCVI / Green Book guidance now no longer mandates Covid-19 vaccination for staff, but NHS England continues to recommend, in national guidance for autumn / winter 2024, that providers promote staff uptake of Covid-19 vaccination. National guidance in this area may of course evolve further over time, so – to future-proof the

Contract wording – we propose to amend it so that the requirement to promote staff vaccination applies where and as indicated in periodic national guidance from NHS England and / or the Department of Health and Social Care, or (where national guidance has not been issued in any relevant period), the JCVI and Green Book apply.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN is supportive of this proposal and we do not have any concerns.

NICE guideline 51 on suspected sepsis Service Condition 22.2 (FL only)

Proposed change:
NICE published a revised guideline (NG51) on Suspected sepsis: recognition, diagnosis and early management. We propose to make two minor changes in relation to how sepsis is dealt with in the Contract.

We propose to delete Service Condition 22.2, which previously required providers to comply with a 2017 NHS England sepsis guidance document, as this is now no longer current. Providers must instead have regard to NG51, as they are required to do (in relation to NICE guidance generally) under existing Service Condition 2.1.6.

We propose to amend the definitions in Appendix 2 of our Contract Technical Guidance for the two National Quality Requirements which relate to the proportion of Service Users who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis. The amendments ensure that the coverage of these standards is consistent with the updated NICE guideline.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN supports the proposed change but would suggest as per NICE guideline (2024) that we also consider including the requirement for the national early warning score (NEWS2) to be used to risk stratify patients with suspected sepsis who are aged 16 or over, are not and have not recently been pregnant, and are in an acute hospital setting, acute mental health setting or ambulance. This was also recommended by the Academy of Medical Royal Colleges .

Medicines Procurement and Supply Chain Framework Agreements and Products Service Condition 39.3 (FL only)

Proposed change:
The Contract contains provisions requiring Trusts to purchase relevant medicines using framework agreements put in place by NHS England. We propose to update the language here to reflect the latest terminology now being used. Rather than referring to NHS England Medicines Framework Agreements and Products, we propose to refer to Medicines Procurement and Supply Chain (MPSC) Framework Agreements and Products.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

As this is only an update to language and seems reasonable, the RCN is supportive of this proposal and we do not have any concerns.

Local Access Policies / non-attendance by people with severe and relapsing mental illness Definitions

Proposed change:
At Service Condition 6.12, the Contract requires providers of acute, community and mental health services to have in place a Local Access Policy – part of the purpose of which is to describe how the provider will manage situations where a patient does not attend an appointment. Via the definition of Local Access Policy, the existing Contract wording requires providers to ensure that any decisions to discharge patients after non-attendance must be made by clinicians in the light of the circumstances of individual patients and to avoid blanket policies which require automatic discharge to the GP following a non-attendance. Guidance published during 2024 by NHS England on intensive and assertive community mental health treatment now makes clear that non-attendance must never be used as a reason for discharge from care for people with severe and relapsing mental illness, and we propose to amend our Contract definition of Local Access Policy to specify this requirement.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
The RCN is supportive of this change, particularly considering the recent Nottingham report and ongoing HSSIB investigation into inpatient mental health settings. Public safety, person-centred need, listening to families and carers are

central to best practice. Contract guidance should stipulate multi-agency working (i.e., police, ambulance) should someone at risk not be contactable.

Medical Examiner Guidance Definitions

Proposed change:
The Contract includes provisions at Service Condition 3.7 requiring the establishment of Medical Examiner offices in acute Trusts and compliance with national guidance on the Medical Examiner system. New regulations came into effect in September 2024, updating death certification arrangements and putting the Medical Examiner system on a statutory footing. Updated national Medical Examiner Guidance was published in consequence, and we propose to update the references in the Contract accordingly.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
Medical examiner offices provide an independent review of deaths, which can help improve patient care and public health. Medical examiner offices in Trusts can work to address systemic healthcare errors and prevent future patient harm.

Appendix 2: Proposed changes we aren't intending to respond to

Appropriate listing of services on e-RS Service Condition 6.10 (FL only) and Definitions

Proposed change:
It is important that providers list their services appropriately on e-RS, distinguishing between:

- services which are subject to the statutory arrangements for patient choice of provider and which should therefore be visible to GPs from any ICB; and
- services which have been commissioned only by specific ICBs and should only be available for referrals from GPs from those ICBs.

There is a requirement to this effect in Service Condition 6.10, with the Contract using the same language which e-RS has used – referring to patient choice services being listed on the "Secondary Care Menu" and locally commissioned services in the "Primary Care Menu". Now that e-RS has moved away from using these terms, we propose to amend the contract to reflect this change in terminology.

Sharing by providers of "qualifying contracts" Service Condition 6.15 (FL) and 6.4 (SF)

Proposed change:
For the patient choice regime to work, it is essential that ICBs operating on an NCA basis with a provider have sight of the qualifying contract whose terms are to apply to any NCA which the provider undertakes. Our Contract Technical Guidance states that a provider accepting an NCA referral must be prepared to share the Particulars of its qualifying contract with the patient's responsible commissioner. We now propose to make it a contractual obligation on the provider, on request by the commissioner, to share its qualifying contract, in complete, up-to-date and unredacted form, with any ICB whose patient has been referred to it on an NCA basis.

Prior Approval Schemes Service Condition 29.8-11 (SF only)

Proposed change:
The full-length version of the Contract includes provisions for each commissioner to notify the provider of any Prior Approval Schemes (PASs). PASs give effect to a commissioner's local commissioning policies, for example in terms of clinical criteria for patients to access specific treatments, technologies or medications. The provider must comply with any properly notified PAS in how it manages referrals and provides services – but PASs must not operate contrary to patient choice legislation and guidance. Further details on PASs are contained in our Contract Technical Guidance (paragraph 42). A number of commissioners have suggested to us that we should include the provisions on PASs in the shorter-form version of the Contract also. This would allow commissioners to ensure that their local commissioning policies are given effect across all the providers which their patients attend, whether those providers are operating under the full-length or shorter form version of the Contract. We agree that this would be sensible and therefore propose to include a condensed version of the Contract provisions relating to PASs in the shorter-form version of the Contract.

Aggregation of payments Service Condition 36.11 (FL only)

Proposed change:
The default position under the Contract is that each commissioner makes its own payment to the provider for services received by its population – but there is a provision whereby all payments can be "aggregated" and made by the co-ordinating commissioner on behalf of all the other commissioners. We have proposed minor amendments to make these arrangements more flexible, allowing aggregation across specific services or commissioners only.

Suspension General Conditions 16.1-3 (FL) and 16.2 (SF)

Proposed change:
We propose to make minor changes to make it clear that suspension may continue until the Co-ordinating Commissioner is satisfied that the failure or concern which led to the suspension has been rectified to its reasonable satisfaction.

Biosimilars Service Condition 39.11 and Definitions

Proposed change:
In recognition of the increasing importance of biosimilars in the provision of biological medicines, we have added a requirement at Service Condition 39.11 for providers to use all reasonable endeavours to ensure that Service Users are prescribed best-value biological medicines where these are required in line with Guidance on Biosimilar Medicines.

Energy purchasing Service Condition 18.4 (FL only) and Definitions

Proposed change:
The Contract includes a requirement on Trusts relating to the purchase of electricity from renewable sources. NHS England has now announced a new Central Energy Purchasing Agreement (CEPA) which all Trusts are strongly encouraged to use. We propose to update the Contract requirement to reflect CEPA, so that a Trust must either:

- Make all of its energy purchases through CEPA; or
- Ensure that energy is purchased at a lower price than that available through CEPA and that electricity is purchased from a supplier with a fuel mix containing at least 55% of energy generation from renewable and low carbon sources.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Modern slavery *Service Condition 39.9 (FL only) and Definitions*

Proposed change:
A separate consultation is under way on draft health service-specific regulations and statutory guidance on tackling modern slavery in NHS procurement. We propose to add a requirement to the Contract on Trusts to comply with the regulations and to have regard to the guidance, as and when both are approved, including in relation to the carrying out of modern slavery risk assessments. The draft guidance envisages that risk assessments will be recorded in the NHS e-commerce system.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Our position on this depends on the regulations and guidance produced.

Payment for Services Paid for on an Activity Basis Particulars 3A, 3C, 3D Service Conditions 6.13A, 29.5, 29.10.1, 36.2A-C Definitions

Proposed change:
A separate consultation will be published on the draft 2025/26 NHS Payment Scheme. To ensure that NHS services remain affordable, the consultation proposes changes to arrangements for payment for services paid for on an activity basis. Each commissioner would have the ability to specify a maximum annual financial value which it would pay to any provider (with planned services over the value of £100k) for all services normally paid for on an activity basis. We have proposed provisional changes to the draft Contract to give effect to the new arrangements being proposed in the Payment Scheme consultation. We will confirm the final arrangements once the outcome of the Payment Scheme consultation is known. Stakeholders wishing to comment on the substance of the proposals around payment for elective activity should do so via the NHS Payment Scheme consultation. Our consultation on the draft Contract is only seeking views on the changes we have made to incorporate the payment proposals into the Contract.

The following changes have been made to allow commissioners to notify and apply a payment limit contractually:

- Contract Particulars: Changes have been made to Schedule 3 to mention inclusion of any Notified Payment Limit under the API or for locally priced activity, and to note that the Expected Annual Contract Value should align with any Notified Payment Limit.
- Service Conditions: Changes have been made to confirm that any Notified Payment Limit will not impact on the obligation to accept referrals under Patient Choice; to include an obligation to agree an Indicative Activity Plan if a payment limit has been notified; and to require the provider to report activity by reference to any Notified Payment Limit. A section has been added at SC36.2 to note that the commissioners' payment obligations are limited to the value of any Notified Payment Limit and to describe the timescales for notifications.
- General Conditions: Definitions have been added for Notified Payment Limit and Services Paid for on an Activity Basis.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

Procurement Act 2023 Particulars Contract Award Process General Conditions 13.1, 17.8 (SF 17.3), 17.10.18 (SF 17.5.8)

Proposed change:
To recognise that there may be a small number of contracts for healthcare services which are procured under the Procurement Act due to the inclusion of high cost associated goods or non-healthcare services, we have updated the Particulars and the associated General Conditions to include this possible route.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

NHS Digital Architecture Principles Service Condition 23.7 (FL only)

Proposed change:
We propose to streamline various existing requirements relating to information technology systems and software, introducing a shorter over-arching requirement for providers to have regard to the NHS Digital Architecture Principles.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: