2026/27 NHS Standard Contract: A consultation

FODO and NCHA joint response

What is your name?

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What is your email address?

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What is your job title?

Policy and public affairs officer

What organisation are you from?

NCHA – The Association for Primary Care Audiology Providers and FODO – The Association for Eye Care Providers

What type of organisation is this?

☒Other

Are you responding as a member of the public?

☒No

The consultation paper and the draft Contracts are available on the 2026/27 NHS Standard Contract webpage. You need to read these documents before responding to this consultation.

For each question, please indicate whether a) your organisation supports the proposal, b) your organisation does not support the proposal, or c) the proposal is not applicable to your organisation, and add comments where relevant.

National quality requirements

National Quality Requirements - Cancer and Urgent Care

Support proposal?

(Required)

☒Not applicable

Comments: NA

National Quality Requirements – Talking Therapies

Support proposal?

(Required)

☒Not applicable

Comments: NA

Local Quality Requirements

Support proposal?

(Required)

☒Yes

☐No

☐Not applicable

Comments:

We welcome the NHS Standard Contract being clearer about the need to meet diagnostic waiting time targets (DM01) and making these a more explicit part of the annual planning round. This is especially important given the massive impact that delayed diagnostics have on

- individuals' wellbeing (anxiety etc) and health outcomes (delayed treatment)
- the wider NHS performance – e.g. knock-on effects on 18-week RTT times

The challenge is that ICBs have access to this data already but are failing to act on it.

For example, hospital audiology DM01 datasets demonstrate major capacity issues, yet they also show patients can be seen in the community more quickly. Delivering the 10 Year Health Plan for adult hearing services, by shifting more care from hospital to community is, therefore, clearly the solution. Yet, ICBs are doing the opposite by rationing access to community audiology services through using IAPs to balance the books, even though these out of hospital services cost 20-25% less than the same care when delivered in hospitals. The result is that hospital audiology DM01 will remain poor, the 18-week RTT for ENT will continue to worsen, and the NHS will not balance its books. Hence, despite the existing data, ICBs are failing to use it as a strategic lever, thereby impacting patients, costing the NHS more and failing to meet the government mission of tackling 18 week RTT targets.

ICBs tend to also ignore that excessive waiting times are often indicative of deeper system level issues and these need to be addressed. The recent Wes Streeting commissioned Kingdon review into hospital children's hearing services is one such red flag. However, little has changed since its publication and IAPs continue to be imposed on out of hospital adult hearing services. Whereas ICBs should in fact be commissioning more adult care out of hospital, freeing up hospital ENT and audiology capacity to manage people with medical/complex needs.

There is therefore an urgent need for ICBs to understand what is driving DM01 performance and act on this. In the case of audiology/ENT, this will require them to deliver the 10 Year Health Plan – shift care from hospital to the community, speed up access to self-referral for audiology and invest in prevention.

Additions and updates to reflect national priorities and guidance

Equality Act 2010

Support proposal?

(Required)

☒Yes

Comments: NA

Health Inequalities Action Plan

Support proposal?

(Required)

☒Yes

Comments: NA

Martha's Rule

Support proposal?

(Required)

☒Yes

Comments: NA

System Collaboration

Support proposal?

(Required)

☒No

Comments:

We fully support genuine system collaboration, where ICBs and providers focus on meeting local needs in a safe, efficient and effective way. That however is not what is happening.

NHS England is sending down a clear message to ICBs to balance the books at all costs, rather than ensure they secure the best value for money and control total costs in a safe and effective way.

NHS England messaging also risks signalling to ICBs that they should focus on avoiding "destabilising the financial position of any other organisation", without sufficient safeguards in place for patient access and outcomes. The problem is that, too often, such messaging translates to hospitals claiming that any shift of services to the community will destabilise their organisation, and ICBs ignoring the financial stability of non-hospital providers when they make decisions in favour of hospitals. It would be better to ensure the NHS Standard Contract and Technical Guidance are used to challenge this structural bias towards the hospital model of care, not further entrench it.

Given many out of hospital eye care and audiology services cost less, and improve access and choice for patients, it might mean some services currently delivered in the hospital need to be decommissioned in order to deliver the 10 Year Plan – especially the left shift to community.

Unfortunately, the current approaches used to balance the books (including ad hoc use of non-evidenced IAPs) continue to pose a risk to patient access and outcomes. Framing this as system collaboration only increases risk and cost. There are far better and safer ways to balance the books and we hope leadership will engage constructively in exploring these options to turn the tide on poor system performance.

Outlier Management

Support proposal?

(Required)

☒Yes

Comments:

We support the use of evidence-based tools to manage outliers, but any new process should be subject to consultation. This is especially true if any new process is to have speciality specific domains as this will help minimise the risk of bias being built into any methodology.

Antimicrobial Usage

Support proposal?

(Required)

☒Yes

Comments: NA

Local Policies

Support proposal?

(Required)

☒No

Comments:

While we fully support the need for proactive/ongoing dialogue between commissioners and providers, and for material policies to be shared between parties as stated, we think it would be unworkable to set a condition that "such policies should be deemed to be incorporated into the contract on receipt". This is not how safe health systems work. It is important for any changes to policies to be fully understood/consulted on before being incorporated into a contract.

Contract Management

Support proposal?

(Required)

☒Yes

Comments: NA

Service Development and Improvement Plans and Data Quality Improvement Plan

SDIP - UK Standard for Microbiology Investigations

Support proposal?

(Required)

☒Not applicable

Comments: NA

SDIP - C. difficile infection ascertainment

Support proposal?

(Required)

☒Not applicable

Comments: NA

Flex-Freeze Variance and DQIP

Support proposal?

☒Not applicable

Comments: NA

Safeguarding

Violence Prevention and Reduction Standard

Support proposal?

(Required)

☒Yes

Comments: NA

Safeguarding Children and Adults

Support proposal?

(Required)

☒Yes

Comments:

We support the need to proactively take steps to prevent abuse by responding to early risk factors or indicators. However, it is important that ICBs recognise that early risk factors/indicators will be influenced by the type of service and population seen. For example, a mental health service for children and young people with long term needs will have different risk

factors/indicators when compared to a much lower risk adult diagnostic service for hearing loss.

Mental Capacity Act – Learning Disability

Support proposal?

(Required)

☒Yes

Comments: NA

Green NHS

Nitrous Oxide Toolkit

Support proposal?

(Required)

☒Not applicable

Comments: NA

Capital Investment

Support proposal?

(Required)

☒Yes

Comments:

We would like to see guidance for trusts that ensures they consider the environmental case for using existing capacity out of hospital to deliver the same services before they allocate capital investment to new hospital buildings/capacity.

Issuing such guidance as part of the Green NHS initiative will also help deliver the 10 Year Health Plan, by ensuring the NHS shifts care from hospital to community where services can be delivered by existing primary care provider capacity/infrastructure. For example, primary care audiology, optometry/opticians and pharmacies which have the workforce, clinical capacity and diagnostic infrastructure to deliver NHS care without new CapEx and without adding to the NHS carbon footprint.

Doing this will help ensure efficient resource allocation, allow more NHS funding to go into direct patient care, and help reduce the carbon footprint, for example, by avoiding building infrastructure and reducing the miles patients and staff must travel to NHS services.

2026/27 NHS Payment Scheme

Aligned Payment and Incentive Changes

Support proposal?

(Required)

☒Not applicable

Comments: NA

Activity Management Provisions

Indicative Activity Plans

Support proposal?

☒No

Comments: Please see our response to the escalation process below

Activity Management Processes

Support proposal?

☒No

Comments: Please see our response to the escalation process below

Escalation Process

Support proposal?

(Required)

☒No

Comments:

The consultation sets out how the business case for this change is that 50% of current escalations were found in favour of the provider, but in 90% of those cases the commissioners were "only found either not to have considered the equality or quality impacts of their plan, or more often, not to have discussed their considerations with the provider". This suggests ICBs have not been doing what they should do, and it is unclear how that triggers the proposed removal of the escalation process.

That said, we welcome changes to the use of the NHS Technical Guidance in setting IAPs, including a "mandatory obligation" to follow guidance. We also welcome the change to paragraph 42.5 in the Technical Guidance stating "commissioners **must** have undertaken" analysis of demand, capacity and the impact on waiting times. This is the right type of safeguard for patients.

The challenge is that paragraph 42.26 goes on to say that if a commissioner fails to follow this mandatory guidance the provider must proceed to the Dispute Resolution process as per GC14. However, this process is complex and prolonged. It is also unclear why NHS England would not make the proposed changes (mandatory actions) and keep the existing escalation process and assess how effective this is before removing it.

In our experience ICBs will fail to analyse demand, capacity and the impact on waiting times, as if they did this the use of IAPs (as they are currently being used) would reduce significantly. Instead ICBs might be required to focus on delivering the 10 Year Health Plan rather than enforcing workarounds on out of hospital providers.

We would therefore ask for NHS England to reconsider the proposed approach

- keeping the proposed changes paragraph 42.5 of the Technical Guidance
- but for 2026 retain the escalation process to see what impact the improvements to the Technical Guidance have on the correct use of IAPs

This will help keep the dispute resolution process free for other contractual matters.

Further comments

NHS England would welcome further suggestions for improving the Contract.

Please add any further comments you may have here:

We note that the pricing team has more explicitly set out how it plans to relook at its approach as part of delivering the 10 Year Health Plan. We would welcome more information on how the NHS Standard Contract team will be considering changes it can make to help deliver the three big shifts in the 10 Year Health Plan. For instance, the shift from hospital to community could be helped by more structured guidance on the use of IAPs and the need for ICBs to engage with a wider range of stakeholders to establish facts/understand the evidence as part of the decision making process. We would be happy to support such work.

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