

GP Contract Imposition 26/27

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Introduction

- These slides have been prepared by the LMC to summarise the main headlines around the imposed 26/27 GP contract
- The final details, including exact wording and changes to the core contract are not yet published but we expect this to happen between now and 1st April
- NHSE & DHSC met with the BMA's GP committee executive only once, before imposing this contract. They badged this year's process as a "consultation" and have declined to meet Dr Katie Bramall and her team again during this period
- On 26th February, GPCE voted to reject the contract. GPs in England will now be polled to ask their view on the next step in escalation against the government's approach to general practice [GPC rejects contracts proposal and gives vote to GPs](#)
- We will continue to update you as more detail is released. Please contact us if you have questions at humberside.lmcgroup@nhs.net

Headline uplifts 2026/27

- Provisional combined GP contract and PCN DES uplift of £485m. This breaks down into £416m going into core practice and £69m into PCN DES and is designed to include “national cost pressures” e.g. list size
- The combined total value of the GP contract is therefore now just under £13.9 billion
- The £485m represents a 3.6% cash increase or 1.4% real terms growth (this is relative to the GDP deflator, the strange economic measure used by DDRB which is currently 2.23% - probably not worth trying to understand this!!)
- The funding includes an assumption of a staff pay uplift of 2.5%, which is what the government have submitted as their pay recommendation to DDRB. If DDRB award less than this, money won't be taken out. If they award more, the global sum will be updated and money from April back-dated.

Global Sum funding uplift 2026/27

Context:

- April 2023 Global Sum £102.28 (£104.73 post-DDRB)
- April 2024 Global Sum £107.57 (£112.50 post-DDRB)
- April 2025 Global Sum £121.79 (£123.34 post-DDRB)
- April 2026 Global Sum £128.69, which is a £5.35 (4.3%) uplift
- This might change if the DDRB recommendation is different or the government make any further changes
- This not all new money!!!

Funding breakdown

Core

Includes: Global Sum,
QOF, SFE
reimbursements,
Advice&Guidance,
premises

Uplift in 2026/27: £708
million (includes
transfer from PCN
budget)

PCN

Includes: PCN funding
including ARRS

Uplift in 2026/27: minus
£223 million (net
difference after £292
transfer into core)

Total

Includes: Core funding
plus PCN funding

Uplift in 2026/27: £485
million (net uplift)

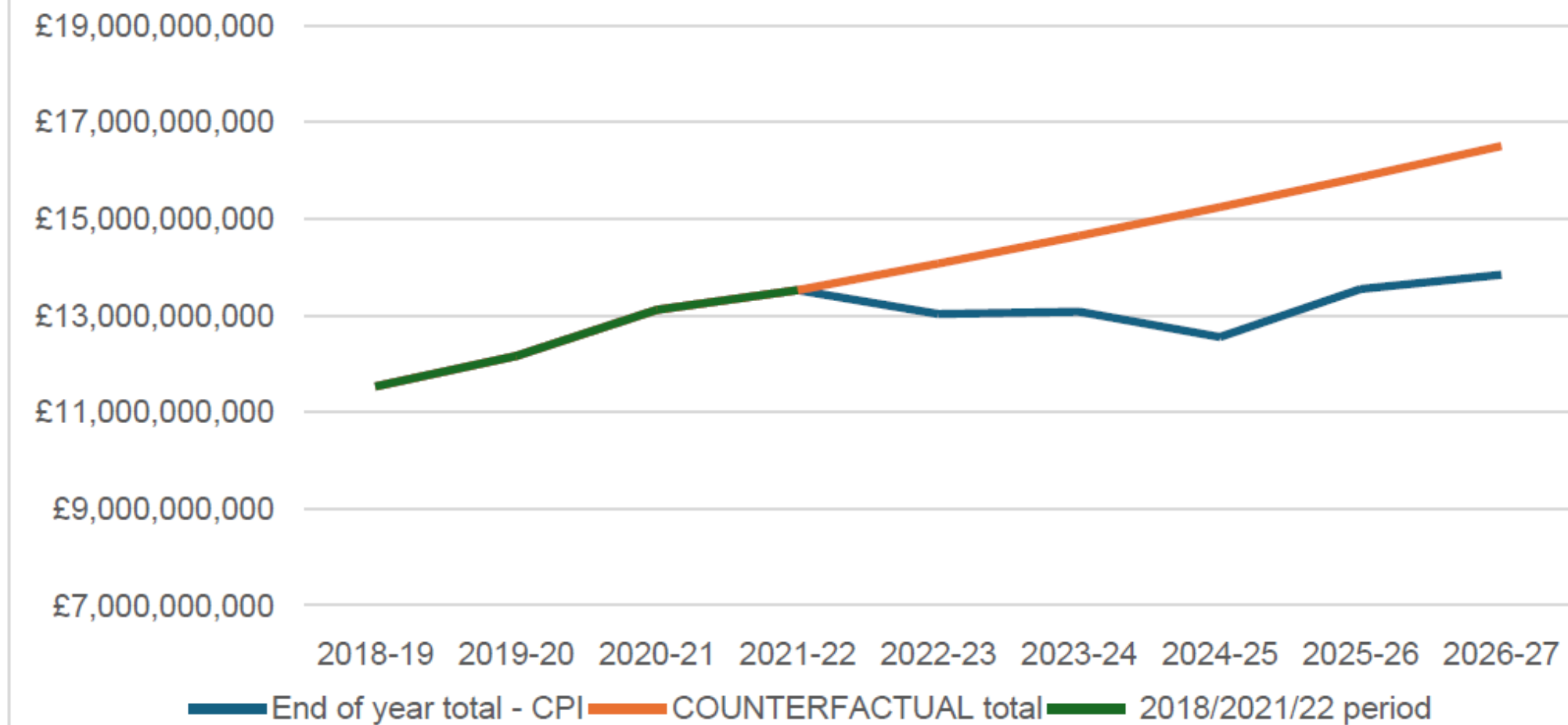
QOF and OOHs deduction

- QOF point value will rise from £225.49 to £227.95, an increase of £2.46 (1.1%) following the change in the CPI
- OOHs deduction falls from 4.75% to 4.7% due to the exclusion of the Advice and Guidance funding (equivalent to £1.28 per wt'd patient)
- So overall, the OOHs deduction increases by just 19p from £5.86 to £6.05

SFE reimbursements

- Sickness, parental, study and suspension leave reimbursement payments will rise by 2.5%
- This amount may change if the DDRB recommendation is for >2.5% as with other staff costs

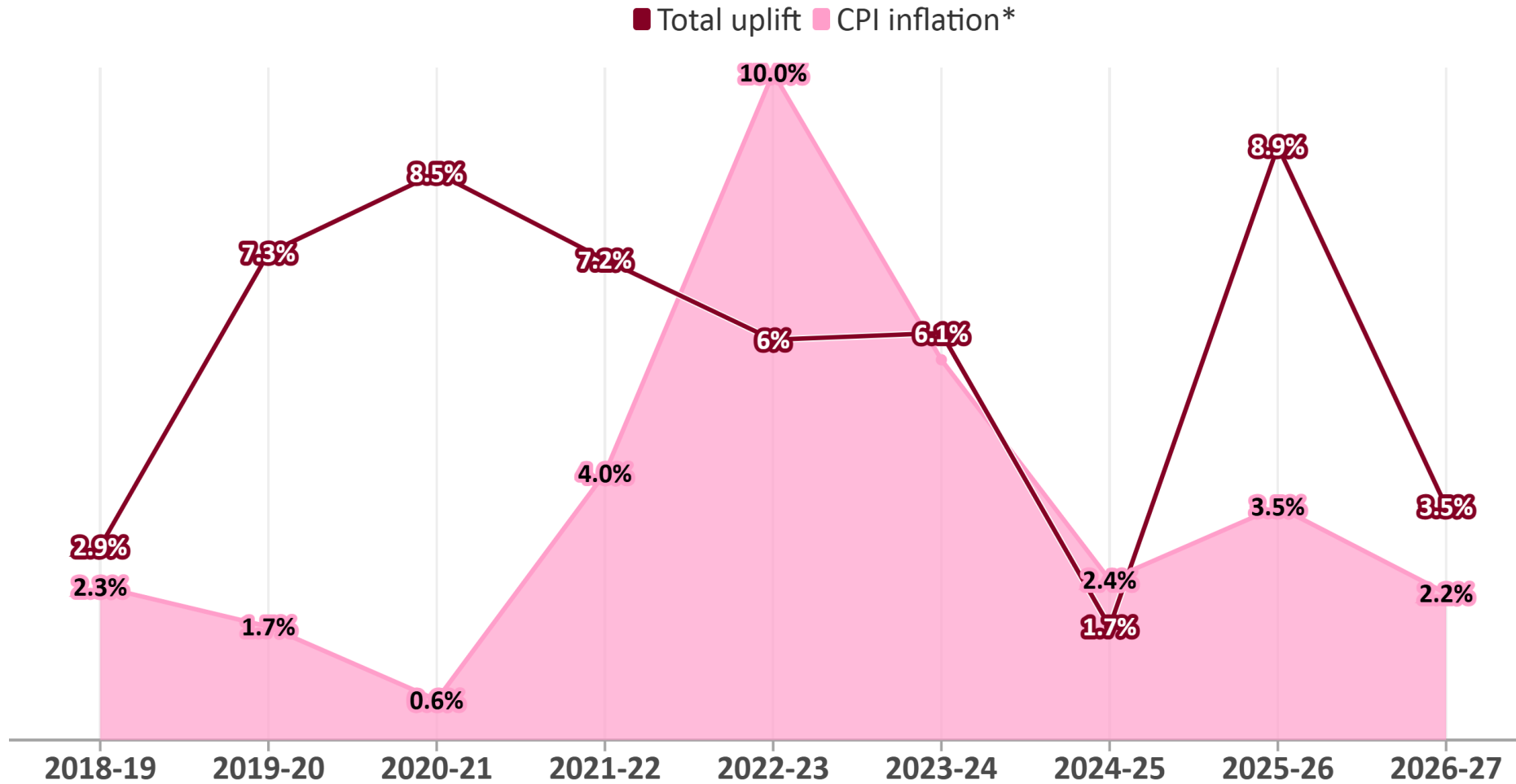
Where would contract funding be had real-terms growth continued?



Graph A: Total GP contract funding at financial year end from 2018-19 to 2026-27, and where total funding would be had the average real-terms growth of 4.1%, seen between 2018/19 and 2021/22, continued between 2021/22 and 2026/27. All figures are real terms, 2026/27 prices, adjusted for CPI inflation as per OBR financial year average indices (November 2025 Economic and Fiscal Outlook)

Total GP contract funding compared to CPI inflation

Annual % change



3 March, 2026

*OBR Nov 2025 financial year average indices.

Advice and Guidance

- Funding for Advice & Guidance is 2025/26's existing funding (£80m) + £2m uplift = £82m
- This goes into Global Sum and becomes recurrent and contractual - £1.28 per weighted patient
- The national Advice and Guidance ES is **retired** – there will be no continuing IoS payments
- Mixed messaging from NHSE over 'advice and refer' – they insist it is not mandatory and GPs retain the right to refer. However, there are at least 2 confirmed examples of hospital trusts being told something different
- The contract does specify that “**Local referral guidelines must be agreed across primary and secondary care**” – this will continue to be a key focus and purpose of the LMC team

QOF

List of full changes in [Annex B](#)

- 18 points worth £25m (new money) added to QOF in 2026/27 for indicator changes with the total number of indicators going from 44 to 43
- Key proposals include:
 - Updating childhood vaccination indicators to reflect JCVI recommendations
 - Replacing diabetes foot check indicator with a new indicator rewarding delivery of **all 8 care processes** (including urine ACR testing)
 - Supporting practices to manage obesity by introducing two new indicators – referral & prescribing
 - Expanding the provision of annual blood glucose monitoring
 - Creating a new indicator for heart failure patients with reduced ejection fraction (HFrEF) to ensure delivery of the NICE-endorsed four-pillar model of treatment
 - Four blood pressure monitoring indicators to be replaced with two combined indicators
 - Supporting individualised treatment targets for frail patients
 - Increasing the upper threshold for the atrial fibrillation indicator for assessing stroke risk
 - Vaccination threshold alternatives to reward the highest of achievement or % improvement in previous 2 years – no further detail on this but is intended to ensure those working in the most challenged or deprived areas are not unduly penalised for lower vaccine uptake

PCN ARRS

- The restriction on ARRS funding being claimed only for recently qualified GPs (currently up to 2 years post-CCT) will be **removed** so that any employed GP may be eligible
- The maximum reimbursement for GPs will be increased to the ‘top of the salaried GP pay range’ (£114,743 – this is expected to be reviewed after DDRB announcement)
- PCNs will be able to claim reimbursement for GPs up to a maximum of the top of salaried GP pay range **plus employment on-costs on top of that**
- Flexibility will be increased to allow PCNs to also recruit non-direct patient care roles from within the ARRS sum, subject to local commissioner agreement – we don’t fully understand what this might mean but will work with ICB colleagues to support PCNs who request this. A potential opportunity to use your ARRS budget fully even if you’ve run out of clinical spaces...

“GP Employment Reimbursement Scheme”

- Being funded by taking the PCN DES CAIP monies (£292m) and shifting them into a new practice-level GP employment reimbursement scheme
- Reimbursement levels unclear at present to be determined potentially via SFE and ARRS
- Original proposal was a set of access metrics where the practice received funding on a sliding scale based on access, so may have employed someone and then found they didn't hit the levels needed to get the pay. This has been removed but activity levels of this scheme will still be monitored to *“inform and support”*...
- Reduces PCN monies by shifting directly to practices
- Reduces potential risk of funds being lost and shifted into SNP contracts/neighbourhood plans
- There are no further details of this scheme, or how it differs from the widened GPs in ARRS criteria

Expansion of RSV cohort/PCN vaccinations

- Programme to cover:
 - All registered patients who are resident in Care Homes for Older Adults
 - All registered patients aged 80 and over who have not previously been vaccinated in line with JCVI recommendations
 - There will be new requirements in the **Network Contract DES** to increase the uptake of seasonal and routine vaccinations by residents of older adult care homes
 - Rebadging of alternative providers as “care homes” in order to access core general practice is causing issues generally & will be very relevant here – we are pushing back against this locally

Lung Cancer Screening

- Practices will be required to engage with and share data with the Lung Cancer Screening Programme to ensure patients within the target cohort can be invited for screening
- As the data controller, the GP practice will be required to facilitate the sharing of cohort data with the Lung Cancer Screening Programme
- This includes signing Data Sharing Agreements and Data Processing Agreements with Lung Cancer Screening Programme Providers
- **More guidance will follow from GPC re this given data controller status of partners**

General Practice Staff Survey

- The NHS staff survey will be rolled out to all practice and PCN staff in years when the survey is centrally funded
- Practices will be provided with reports, which *‘can be used to help inform workforce development plans and policies’*
- Participation must not create additional burden for practices
- Unclear whether there will be any support to address issues raised in the survey – currently a criticism of the hospital version

Changes to GP registration & catchment area

- If a patient presents with a paper form for registration, the practice will be required to enter the information directly into the online registration system
- Regulations will be changed so that the digital catchment area is the sole agreed catchment area for the practice
- GP practices must submit changes to their catchment area via the digital tool, which will be approved by their ICB

Pharmacy: Patient Choice & Email Contact

- Nominated pharmacy must be re-confirmed with the patient for any new prescription
- With any new referral made to a community pharmacy service, patients must be offered the full choice of community pharmacies on the NHS England registered list
- Any triage tool practices use must enable patients to choose a provider of pharmacy services according to their preference
- GP practices to have a dedicated and monitored email address for the purposes of receiving consultation information, especially in the event GP Connect is down
- Prescribing information delivered to a practice's registered patient by a community pharmacy to be shared on the DoS

Collaboration with ICBs where a practice requires support

- GP practices will be required to engage with support from ICBs in circumstances where “unwarranted variation” has been identified by the commissioner in contractor performance, and/or the practice is at risk of contractual breach
- LMC would expect to be involved in these discussions early on, both by the practice and the ICB

Cannot ask a patient to call back, or make contact on a different day

- Regulations to be amended to specifically set out the requirement that *'practices must not ask patients to call back, or recontact the practice, on another day'*
- Removal of the requirement that an appropriate response must be provided in the same core hours period, or the next day on which the core hours fall if the contact is made outside core hours – instead will be *'in next working day's core hours'*
- The requirement to not ask patients to call back on a different day is already in the current contract but is being made more explicit. We are waiting to see if the definition of “appropriate response” changes. It is currently:
 - A request for more information
 - An offer of appointment (by any route)
 - Advice or other treatment
 - Redirection to another service, or
 - Details of being added to a waiting list

Same day 'clinically urgent' access

- It will be made explicit in the GP contract regulations that clinically urgent requests (**as defined by the clinical judgment of the GP**) must be dealt with on the same day
- The annual GP contract guidance will reiterate that '*clinically urgent requests should receive same day appointments*'
- We think it's very unlikely that any GP is recognising a clinically urgent case, and not dealing with them on the same day but DHSC feel they need to be explicit...

Unlimited access (no online cap)

- An explicit reference will be added to the regulations that GP practices 'must not cap the total number of requests or queries submitted online' via the software settings
- This is 'in addition to the online consultation system being switched on for the duration of core hours'
- Guidance will be published for commissioners and GP practices 'to support implementation of these contractual changes'
- Likely all online consultation tools will be linked to NHS app to allow closer monitoring

Unlimited access (no online cap)

- The inevitable question then is, what do we do when we are full and overwhelmed?
- We will issue more guidance on this as the contract wording is clarified, but the options are likely to be:
 - OPEL report your practice as 4 (black) when you have reached capacity – new LMC guidance coming on this shortly
 - Normalise longer waits and waiting lists for any non-urgent care, as capacity will have to be redeployed to manage the unlimited access – we will provide patient facing resources to support practices with this.

Displaying opening times for all three modes of access

- The Regulations will be updated to make explicit that patients can expect:
 - that opening times information should be provided for phone line and online consultation availability, in addition to walk-in
 - that this information should also be displayed in the surgery, and in the practice leaflet, in addition to the practice website
 - that the hours displayed for all modes of access must be at least the core hours period (08:00 – 18:30)

Timely access to GP access data to support monitoring

- The GMS and PMS regs will be amended to enable NHS England to contractually require GP practices to 'provide data and information in relation to online consultation and video consultation services'
- The data 'will be extracted directly via the software suppliers'
- Being looked at by the joint GP IT committee (BMA & RCGP) very closely – national guidance to follow

Sub-contracting

- Amendment of the PMS regulations to align with the GMS Regulations around needing ICB approval to sub-contract any services
- Alignment gives commissioners the same powers to object to sub-contracting as in the GMS contract
- Guidance will be drafted *'to support commissioners to enforce the current provisions (in GMS) where existing sub-contracting arrangements are in place'*
- Mostly related to sub-contracting in core hours, which will no longer be the case for most practices in our area after 1st April – contact us if you think this does apply to you.

PCN DES - Continuity of care

- The existing CAIP incentive in the PCN DES will become a core contractual Network Contract DES requirement for PCNs, who will be expected to continue to risk stratify their patients in accordance with need, including to identify those that would benefit from continuity of care
- The entirety of the Capacity and Access Payment funding (including the £292m currently made available to support delivery of this ask in CAIP) will move into core for the “GP Employment Reimbursement Scheme” detailed on slide 13

PCN Cancer requirements

- Expansion of the current wording to provide further clarity for PCNs on what they are expected to deliver
- The changes are proposed to aid PCNs in:
 - delivering the requirements of the contract
 - improving the quality of cancer referrals and early diagnosis rates
 - improving uptake of non-cancer screening programmes

PCN vaccination collaboration

- Proposal to enable practices to voluntarily collaborate for flu and COVID-19 vaccinations under the Network Contract DES
- This will happen by retiring separate collaboration agreements and removing existing exclusions from the Mandatory Network Agreement, aligning with the move to practice-level delivery in 2026/27
- Funding means may still not be financially viable, however PCNs will hold responsibility for their population being covered
- This may be an area where working at scale above PCN level e.g. GP federations, may be beneficial

PCNs to collaborate with ICBs on neighbourhoods

- New requirement in the Network Contract DES specification to explicitly require that '*PCNs **must** work collaboratively with the ICB to achieve greater alignment between the PCN registered list and the neighbourhood*'
- '*This change is not intended to signal widespread reconfiguration of PCNs, it will apply only in limited circumstances and is a safety net where existing arrangements clearly do not reflect local communities*'
- There is a key role for the LMC alongside PCN CDs to ensure any proposed changes are truly needed and in the best interests of patients

Next steps

National GPCE webinars

- Thursday 5 March, 12-1:30pm – [register here](#)
- Tuesday 10 March, 7-8:30pm – [register here](#)
- Wednesday 18 March, 12-1:30pm – [register here](#)
- The LMC will be issuing OPEL guidance shortly & focusing on representing you in discussions around A&G and neighbourhood footprints
- Join the Humberside LMC Essential Updates Whatsapp group
<https://chat.whatsapp.com/LbcAaMuE1U5JbOAu8OySbX>

- We will be working on patient facing information around access for 1st April onwards
- We will share more details as we get them from both NHSE and GPCE
- Look out for BMA GP vote and communication around this

Zoe & the LMC team

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