

Ed Scully and Dr Amanda Doyle
Department of Health & NHS England
Via email

06 February 2026

Close of GMS contract consultation 2026/2027

Dear Ed and Amanda,

Thank you for your constructive engagement throughout the consultation process. For completeness we'd like to take this opportunity, following our second and final consultation meeting on Thursday 22 January 2026, to provide our complete and final comments on the DHSC / NHSE 2026/27 GMS contract consultation, including on proposal PN027. This takes into account all the information provided.

In summary, unfortunately the proposals fall disastrously short of what is needed to provide the necessary support General Practice needs to sustain the extraordinary pressures it is under from both workload shift from other system partners and ever-increasing unmet patient need within our local populations.

You will be aware that 31.1million appointments were undertaken in November 2025 alone - a daily average of over 1.55 million. Practices continue to close or merge to survive, longstanding GP partners are being forced to walk away from their vocation, and the emergence of GP underemployment, which we first raised in August 2023 with then minister Neil O'Brien, is now widespread. Whilst there are aspects within some of the recommended changes that are welcome, such as the changes to the GP ARRS arrangements and flexibilities, these do not go anywhere near far enough to stabilise practices or help them and their staff teams feel safe.

Whilst we recognise the national fiscal situation, the financial uplift proposed is below CPI and wholly inadequate for the pressures and requirements being placed upon practices. Our financial analysis of practice accounts data has shown that business costs, including large increases to staff costs, have accounted for much of the additional funding put into the contract in 2025/26. In addition, our recent practice finance research, undertaken in collaboration with Practice Index and the Institute of General Practice Management indicates that GP practices in England had already seen a drop in net real terms income per patient in the previous year (2024/25, CPI). Therefore, the level of funding being proposed for 2026/27 will be inadequate to provide sufficient safeguards to practice stability as workload, costs and expenses continue to rise. As discussed, we will share and discuss this data with you in the coming

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weeks, to aid your negotiations within and outside the Department when building the case for increased investment into GMS going forward.

In tandem, there are a number of proposals that we believe will be actively detrimental, both to the profession and the patients that they serve. It is extremely concerning that there seems to be a distinct focus upon moving general practice from the holistic planned care of a registered population to that of fire fighting against urgent care needs in the community, and mitigating pressures on hospital Trusts at the expense of the very nature of a primary medical services contract. General practice as a specialty delivers an extraordinary service. It is still rooted in its community, providing cradle to grave, face to face, expert generalist care.

Without significant additional resource, not to mention both physical and workforce capacity, such an imposed transition must necessarily come at the expense of scheduled care such as that managing long-term conditions, vaccination and immunisation programmes and routine presentations. This will further fragment care and undermine continuity. Indeed, it seems to go manifestly against the Government's stated ambitions of moving from sickness to prevention and 'bringing back the family doctor'. Likewise the QOF proposals risk destabilising locally commissioned arrangements at best, which will have an adverse impact on those populations that can afford it least further widening inequalities.

With specific regard to the proposal PN027, sent on 29th January, we have significant concerns about the underlying assumptions driving the proposal.

There are risks that incorrect patients will be deducted, or patients may be deducted too soon, creating more administrative burdens for practices. Even more likely, is that patients will return and to avoid unnecessary bureaucracy, will present at Emergency Departments. For practices in attempts to re-register. The figure of 0.27% is quoted for those who re-register within three months of deductions. Has NHSE/DHSC been able to scrutinise data to determine how many historic deductions later present in EDs requiring new or temporary NHS numbers? We fear this measure to save resources will actually prove to be a false economy.

Another concern is around social equity. It is likely that this process will most heavily impact practices in areas with transient and vulnerable populations, particularly areas of high deprivation where patients may lack the literacy or means to respond to challenge deductions. These populations typically may have higher than average care needs.

Thirdly there is stability for practices serving such populations. We appreciate the thinking behind reallocations via Carr-Hill, but sudden changes in funding for practices in these areas may prove extremely destabilising. The stated potential of £1 billion of annual funding reallocations needs modelling to appreciate the impact this represents of a significant percentage of annual contract funding. In light of this, an impact assessment needs to be produced and analysed to identify and mitigate against significant disruption.

We are keen to know what data is being used upon which to base de-registration within the proposal, especially given recent issues with, for example, child benefit payments where HMRC data incorrectly identified significant numbers of people as having emigrated. The profession lacks confidence in PCSE to be able to undertake such deductions correctly and accurately.

When patients may be incorrectly identified and subsequently de-registered, this will create unnecessary concern for patients and additional workload for practices, especially when having to re-register at a later date. As stated above, typically such presentations will default to urgent and emergency care settings where a single attendance will cost more than a year's care in a practice setting. We are concerned that any and deleterious consequences for DHSC and Treasury.

Separately to PN027, we hope that due consideration will be given to the alternative proposals we provided in December, both as part of this consultation and in the future. We were heartened to hear of

the support for a number of them, including the potential to reframe the metrics against access with repurposing the CAIP PCN DES funds to ringfence resource for additional GP sessions and roles. GPCE has given serious thought to ways in which the profession can be supported, in a manner which is financially transparent and cognisant of the Government's wider aims. For this reason, we focused upon workforce support and other avenues that will help to boost clinical capacity in practices, whilst providing a clear and transparent use of additional funding.

Finally, we would like to again place on record our disappointment at the changes unilaterally imposed to the GMS contract 'consultation' process for 2026/27 after 22 years of established custom and practice. As the elected representative body of the GP profession, GPC England has a duty and responsibility to represent the views of its members in a frank and honest manner. Even in times of disagreement, it has consistently sought to work constructively and productively with partners in government, often in challenging circumstances for both sides, and will continue to do so. Whilst seeking views from wider partners is to be encouraged, the representative role of GPCE, and its historic position as a negotiation partner around the GMS contract and the GP contractors it represents, should not be undermined, dismissed, diminished or forgotten.

Recognising that this may be outside the control of your departments, the changes to the contract process for this annual cycle have also been disappointing. A 6-week consultation period, running over Christmas and New Year, with a single meeting to discuss proposals (and separate to discussions on the proposed funding levels), is inadequate.

The ultimate result is that the voice of the profession in shaping changes that will have a direct effect upon their working lives has been significantly diluted. Issues that may ordinarily have had the time and space to have been fully worked through are more likely to be imposed without adequate consideration. This is likely to reinforce views amongst the profession of the lack of regard in which GPs are held by Government and subsequently harden the views of our membership.

We would therefore urge a return to a more substantive process going forward and remain willing and open to such future discussions. In particular, we wish to draw attention to the letters from the Secretary of State in March and August 2025 where there was a commitment to negotiate with GPC England to agree a new substantive GMS contract, and we look forward to getting around the table to establish common ground and move things forward.

Yours sincerely



Dr Katie Bramall
Chair, GPC England