



Department
of Health &
Social Care



20 February 2026

Dear Katie,

Close of consultation on proposed 2026/27 GP contract changes

1. Thank you for taking the time to engage with the consultation and for providing feedback on the 2026/27 GP contract proposals. The consultation began on 1st December 2025 and lasted for 6 weeks, with an additional week provided to allow comment on a further proposal introduced during the process. This year we widened the consultation to engage with stakeholders from across the system, these were GPC England (GPCE), Royal College of General Practitioners (RCGP), National Voices, Institute of General Practice Management (IGPM), Healthwatch England, NHS Confederation and National Association of Primary Care (NAPC). The written and verbal feedback received from stakeholders across the system has been constructive and comprehensive, enabling us to refine proposals and address concerns to develop the final package.
2. Following consideration of the feedback received, the package of proposals has now received ministerial and cross-government sign-off and can no longer be amended. These are set out in full in annex A. We are sharing these with you in advance of the public announcement of the 2026/27 GP Contract changes in week commencing 23 February. We ask that you do not share the contents of the package more widely until the contract announcement.
3. We heard strongly that the proposed Access Incentive Scheme risked driving a narrow focus on speed of access, and could present operational, capacity and safety challenges. Stakeholders were clear that increasing GP capacity is the most effective and sustainable way to improve access and patient experience. In recognising this, we will instead use the £292m (currently allocated to the PCN level Capacity and Access Payment) to introduce a practice-level GP reimbursement offer. This change addresses the feedback while maintaining our commitment to delivering 90% same-day access; increasing GP capacity remains the central route to achieving this ambition. As per our original proposals, we will also expect practices to engage with ICB support where unwarranted variation is identified. This may include where practices face challenges in improving GP-to-patient ratios. Overall, this change to the original proposals reflects that we have

listened and are taking forward the most positive and impactful approach, while our intention remains to strengthen same-day access. We will still collect the data against the five metrics set out in the original Access Incentive Scheme proposal during 26/27.

4. Having carefully listened to feedback we have also decided not to proceed with the de-registration of patients proposal. The purpose of the proposal was to enable increased list cleansing activity without putting extra burden on GP practice staff, but we heard strongly the concerns raised about patient continuity and unintended consequences for vulnerable groups. The decision not to take the proposal forward does not impact the ongoing accelerated GP list cleansing programme of work. Where patients remain on a practices' list in greater numbers than expected there may be additional engagement required with that practice.
5. While the practice-level GP reimbursement scheme is the most substantive policy change to the proposals, we have made several refinements in response to feedback. Stakeholder input has helped us to ensure proposal intent will be clearly communicated to the profession and patients and we have heard the importance of developing strong supporting guidance to underpin implementation. This includes providing clearer definitions, strengthening safeguards, and setting out more practical detail on how proposals will work in practice. These improvements do not alter the core intent of the package but reflect the constructive feedback we received and our commitment to delivering a workable, evidence-based set of changes. We are also restarting the publication of contractual guidance to support the implementation of the 2026/27 contract changes. This is in response to feedback that further clarity on some proposals would be helpful for practices.
6. Overall, we believe the 2026/27 contract is making progress against commitments in the 10 Year Health Plan by shifting from treatment to prevention via expanded vaccination programmes, supporting earlier lung cancer diagnosis in the community, bringing back the family doctor through increased GP capacity, and optimising the management of obesity through changes to QOF.
7. We heard a number of common themes, including concerns about increasing workload pressures and the impact on staff morale and wellbeing. We also heard consistent reflections on the importance of clear, accessible patient-facing communication to support safe and equitable access to general practice. We will take this forward by reviewing existing materials, including You and Your General Practice (YYGP), and improved communications which we will be looking to codevelop with stakeholders. We have also received much feedback that provides insightful input to the longer-term work on GMS reform.

8. We would like to thank GPCE for its constructive and detailed engagement throughout the consultation process, including written submissions and ongoing dialogue with DHSC and NHSE. GPCE have provided valuable insight into the practical realities facing general practice, and this feedback has played an important role in shaping the final package.
9. In particular, we heard clearly GPCE's concerns about the risk of overly narrow incentives on access, the importance of strengthening GP capacity as the most sustainable route to improving patient experience, and the need to safeguard continuity and professional autonomy. These views informed our decision to pivot from the proposed Access Incentive Scheme and accept your proposal for a practice-level GP reimbursement offer, as well as our decision not to proceed with proposals on patient de-registration, specifically the removal of the three-month FP69 period. Action to address list inflation will continue through existing processes.
10. We have also reflected GPCE's emphasis on clarity and workability by committing to clearer contractual guidance and supporting materials to underpin implementation. While it has not been possible to take forward all of GPCE's proposals, your contribution has provided important challenge and will continue to inform both implementation of the 2026/27 contract and the wider programme of GMS reform (see Annex B for full list of proposals and responses).
11. Government remains firmly committed to stabilising general practice, ensuring the system is sustainable, valued and equipped for the needs of both the profession and patients. We are also committed to taking forward meaningful GMS reform, providing greater clarity, stability and a stronger foundation for future improvements. We look forward to working with you in future on improving general practice.

Regards,

Dr Amanda Doyle OBE, MRCGP

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Annex A – Final proposals on changes to the GP contract 2026/27

Overall aims of the package

1. The Government and NHS England have heard views from stakeholders, whose contributions have highlighted both the strengths of the proposals and the areas where further clarity or refinement was needed.

GP contract finance

2. The GP contract uplift for 2026/27 is £485m, bringing it to a total of £13,863m, including Advice and Guidance funding. This uplift represents a 3.6% cash increase, or 1.4% real terms growth relative to GDP deflator. This includes:
 - a pay assumption of 2.5% in 2026/27, to revisit post DDRB recommendations, and;
 - funding to cover the costs nationally of other cost growth pressures, including from premises and list growth.

Practice-level GP reimbursement

3. We will introduce a practice-level GP reimbursement scheme, using £292m of repurposed funding from the current PCN level Capacity and Access Payment (CAP). The funding will be available to practices to hire additional GPs or fund additional sessions from existing GPs to support clinical same day urgent access in general practice. The Capacity and Access Payment (CASP and CAIP) will be removed from the Network Contract DES.
4. We have introduced this change in response to feedback during the consultation that this will strengthen capacity, access and improve patient satisfaction, whilst also addressing GP unemployment and underemployment.
5. In order to access funding, for those practices who have a high patient to GP ratio (more than 3,000) they will be required to engage with their ICB on their plans and provide further detail on why they have a high ratio.

Quality Outcomes Framework (QOF)

6. We will make a series of refinements to the Quality and Outcomes Framework for 2026/27 to strengthen alignment with updated NICE guidance and support more clinically effective care. This includes:
 - a. updating the childhood vaccination indicators to reflect the introduction of the MMRV vaccine,
 - b. introducing a new diabetes indicator requiring delivery of all eight NICE recommended care processes,
 - c. adding two new obesity related indicators to support referrals into structured weight management programmes and medicines optimisation, and

- d. updating the Heart Failure indicators to reflect the NICE recommended 'four pillars' of treatment, and
 - e. streamlining by combining and simplifying existing measures.
7. These changes are supported by an additional 18 QOF points (c.£25m) and are intended to enhance clinical outcomes, modernise the scheme, and ensure indicators reflect current evidence and best practice.
 8. Stakeholders recognised the clinical value of the proposed changes and were broadly supportive of updates that better reflect contemporary guidance and strengthen prevention. Feedback also highlighted concerns about additional workload, realistic thresholds, and the need for reassurance that new indicators would not disadvantage practices lacking access to wraparound services. In response, we intend to provide clear guidance on implementation, data requirements and expectations, and to emphasise that the changes are designed to reward meaningful improvement while supporting equity and aligning incentives with improved patient outcomes.

QOF – Childhood Vaccination Improvement Thresholds

9. We will update the QOF guidance to introduce additional improvement thresholds for the three childhood vaccination QOF indicators (VI001, VI002 and VI003) for 2026/27. The Statement of Financial Entitlements will be updated during 2026/27 to reflect this change. These changes are intended to recognise and reward practices, particularly those in more deprived areas that may not meet the existing achievement thresholds but demonstrate meaningful and sustained improvement in vaccination uptake.
10. Current thresholds for these vaccination indicators remain unchanged. However, for 2026/27, practices will have an additional opportunity to earn QOF points by improving against their own baseline, calculated as a two-year average. At year-end, practices will receive whichever points allocation is higher:
 - points based on traditional achievement thresholds, or
 - points awarded on a sliding scale for improvement from baseline.
11. The improvement thresholds will be stretching but achievable, with the lower improvement threshold set at 5 percentage points above baseline for all three indicators, and an expanded range between lower and upper improvement thresholds to reward significant progress. Maximum QOF points available for each indicator remain unchanged.
12. Proposed new improvement thresholds for 2026/27:

- VI001: 5–18 percentage points
- VI002: 5–23 percentage points
- VI003: 5–30 percentage point

13. Feedback on this was broadly supportive, with no concerns raised. We will proceed with the proposal; the approach reflects a consistent message from stakeholders to better support practices in high need areas, reward meaningful improvement, and address inequalities in uptake while continuing to safeguard herd immunity.

Practices must not ask patients to call back another day

14. We will update the contract to specifically set out the requirement that practices must not ask patients to call back, or make contact, on another day. In parallel, we will amend the existing ‘appropriate response’ requirement to provide greater flexibility for non-clinically urgent contacts. Practices will still need to provide patients with a timely appropriate response confirming next steps, but this will be required by the end of the next working day (rather than within the same core-hours period). This does not mean the patient’s non-clinically urgent request must be fully dealt with by then; rather, the patient should understand how and when their issue will be managed.

15. We heard feedback around workload pressure and the need for realistic expectations. There was emphasis that many practices experience day-to-day volatility in demand and tighter requirements may inadvertently increase strain on staff. It was highlighted that patient expectations and communication were integral to making this change work well. In response, we will provide guidance and public messaging on what is reasonable of practices to deliver. The aim is not to remove necessary triage, but to reduce unnecessary deferrals where care can reasonably begin on first contact.

Same-day response for clinically urgent needs

16. We will amend the Regulations to explicitly require that requests identified as clinically urgent, as determined by the clinical judgement of a GP or appropriately trained professional, must receive a same-day response.

17. Stakeholders emphasised capacity pressures and the importance of GP autonomy to determine what constitutes ‘urgent’. We intend to maintain the proposal while being clear that urgency is determined by clinical judgement and that this requirement supports, rather than replaces, holistic care.

No capping of online consultation volumes

18. We will amend the Regulations to explicitly require that online consultation systems must not cap the number of requests that can be submitted during core hours. This will ensure that patients are able to contact their practice throughout core hours via all routes of access, and that online consultations operate with the same parity as telephone and walk-in access.
19. We heard feedback about safety, capacity and wellbeing. However, this is not a new requirement and is about making clear via the contract that online consultations should not be capped. We will maintain the proposal to enable equitable patient access to digital routes and avoid artificial restrictions that can exacerbate health inequalities.

RSV older adult cohort expansion

20. We will amend the Regulations to require that practices offer RSV vaccination to all registered older adult care home residents and all patients aged 80 and over who have not previously been vaccinated, in line with JCVI recommendations. Practices will receive an Item of Service fee for each vaccination.
21. We heard strong support for the value this has for public health, while issues around workload and practical implementation were raised. We propose to proceed, while ensuring communication and guidance support practical delivery.

Vaccination requirements in care homes

22. We will amend the Network Contract DES to include explicit requirements for PCNs to ensure that eligible older adult care home residents are identified and offered seasonal and routine vaccinations in line with national recommendations, with supporting guidance to clarify roles and responsibilities. This does not necessarily mean that PCNs are responsible for delivering the vaccinations.
23. Overall, the aims of this proposal were welcomed by stakeholders, while questions were raised about roles and equity. We will clarify responsibilities at PCN level through supporting guidance.

Embedding Advice and Guidance (A&G)

24. We will amend the contract to embed Advice and Guidance within core funding, requiring practices to use A&G prior to or in place of a planned care

referral where clinically appropriate and to follow locally agreed referral pathways, including Single Point of Access models once introduced. Advice and Guidance has shown clear value in supporting timely specialist input and reducing unnecessary referrals. The A&G Enhanced Service will be retired.

25. Stakeholders also reflected that the proposal needs to be implemented carefully to avoid adding pressure on practices, particularly while systems and processes mature. They emphasised the importance of clear communication for both practices and patients, early engagement on the development of Single Point of Access models, and assurance that expectations will be proportionate and support consistent, equitable pathways. In response, while we are maintaining the proposal, we will ensure guidance provides greater clarity on how A&G should operate in practice, including expectations around communication, triage standards and monitoring.

Access to data to support monitoring

26. We will amend the Regulations to align with existing Cloud Based Telephony (CBT) requirements, to require practices to provide timely data and information related to online and video consultation services, enabling consistent monitoring of access, patient experience and system performance.
27. There was broad recognition of the value of transparent, high-quality data for understanding demand patterns, patient experience and inequalities. Feedback was given on the importance of transparency in how data is used. We will clarify that the intention is not to performance manage practices, but to support a clearer understanding of access, highlight where improvement may be needed, and help identify inequalities.

Amending Cancer Requirements in the Network Contract DES

28. We will amend the Network Contract DES to provide clearer requirements for improving cancer referral practice, early diagnosis, and screening uptake. The updated wording introduces explicit expectations around reviewing referral quality against NICE Guideline NG12, strengthening and standardising safety-netting (including use of electronic tools), and setting out clearer responsibilities for proactively identifying and supporting eligible patients to engage with cancer and non-cancer screening programmes. These amendments will retain the high-level intent of the DES while providing additional operational clarity to support consistent, effective delivery across PCNs.

29. Stakeholders were generally supportive and welcomed the intent to provide clearer expectations for PCNs and the focus on improving early diagnosis and screening uptake was welcomed. Stakeholders also highlighted that much of the relevant data sits at practice level and encouraged us to ensure new requirements are practical and proportionate. In response, we intend to provide clearer supporting guidance that sets out what is expected of PCNs, how responsibilities can be shared across the system, and how this work can support equitable screening uptake, including through collaboration with Voluntary, Community and Social Enterprise (VCSE) partners.

GP engagement with the Lung Cancer Screening Programme

30. We will amend the Regulations to require practices to share data with the Lung Cancer Screening Programme to support the operation of the programme.

31. We heard broad support for the aims of the Lung Cancer Screening Programme, with stakeholders recognising its value in enabling earlier diagnosis and improving outcomes for patients. Feedback highlighted a need for clearer communication around roles and indemnity, particularly given that practices act as data controllers. At the same time, stakeholders acknowledged the importance of accurate patient identification and proactive outreach, especially for underserved groups. In response, we are maintaining the proposal and will set out supporting guidance to clarify responsibilities and provide reassurance around data use and protections. As part of GMS reform, we will explore with NHS Resolution whether data breaches can be included as part of general practice indemnity. Our intention is to ensure the Programme can be delivered consistently, supporting GPs to play their vital role in identifying eligible patients.

Continuity of Care (risk-stratified cohorts)

32. We will make it a core requirement for PCNs to identify and prioritise cohorts for continuity of care using risk stratification tools as part of their core activities. This will make continuity a core expectation within primary care and support future work to embed more meaningful continuity models in subsequent contract reform.

33. We heard strong support for continuity of care as a central part of good, routine primary care, with stakeholders emphasising its importance for clinical outcomes and patient experience. Feedback also discussed meaningful continuity and the need to avoid additional administrative burden without dedicated funding. In response, we intend to maintain the requirement while being clear that the ambition is to strengthen continuity where it has the

greatest clinical impact and to use this cycle to signal continuity as a core activity. While risk stratification had previously been incentivised, making it a core contractual expectation signals a clear shift from optional improvement activity to a standard requirement across practices. We will take forward further work through future contract reform to develop more effective and sustainable approaches to embedding continuity across general practice.

Streamlining GP registration

34. We will amend the Regulations to mandate the use of online registration in all cases of registration. Practices will be required to enter information from paper registration forms into the national online registration system, and ensure that changes to practice boundaries which are submitted through NHS England's digital catchment tool are approved by the ICB.
35. There was broad support for the intention to simplify and standardise registration processes, with stakeholders recognising the value of ensuring that information from paper forms is entered directly into the national system. Feedback also highlighted concerns about digital exclusion, administrative workload and the risk of creating a de facto "digital-first" approach for patients who may struggle to use online routes. In response, we are maintaining the proposal while being clear that protections for non-digital and assisted routes will be set out in supporting guidance. Our intention is to streamline registration processes, reduce unnecessary variation, and ensure that all patients are able to register with a GP practice in a clear, accessible and consistent way.

Patient choice of pharmacy

36. We will amend the Regulations to expand the provisions on nominated dispensers, requiring practices to reconfirm the nominated pharmacy whenever a new prescription (not a repeat prescription) is issued, and to ensure that referrals and triage tools used for community pharmacy clinical services offer patients a full choice of providers. We expect in practice that most practices do this already, and this should not add additional burden to appointments.
37. We heard general agreement between stakeholders that supporting patient choice is important and that many practices already operate in a way that protects patient preferences. Some stakeholders sought clarity on the scope of the new requirements and raised concerns about the potential for unnecessary bureaucracy. In response, we are maintaining the proposal but will clarify expectations to ensure the change is proportionate, focused on safeguarding genuine choice, and complements existing digital tools. Our

intention is to strengthen transparency and ensure that patients are consistently offered a full choice of community pharmacies without placing undue burden on practices.

Dedicated GP email for pharmacy communications

38. We will amend the Regulations to require practices to have a dedicated, monitored email address for receiving information from community pharmacies in the event that GP Connect is unavailable and for new or emerging pharmacy activity that is not yet supported through GP Connect, for example, the introduction of independent prescribing in community pharmacy. The email address must be kept up to date and shared with the Directory of Services.
39. Stakeholders recognised the importance of ensuring reliable communication channels between community pharmacies and general practice, particularly where digital systems such as GP Connect are unavailable. We will ensure clarity on when the dedicated email address should be used and how it complements existing digital pathways. We will also make clear that existing practice e-mail address can be used for this purpose, and the provision will not require a new one to be set up. Our intention is to strengthen patient safety and ensure timely transfer of information, while keeping the requirement as simple and proportionate as possible for practices.

Additional Roles Reimbursement Scheme (ARRS)

40. We will amend the Network Contract DES to remove the restriction that ARRS funding can only be claimed for recently qualified GPs, increase the maximum reimbursement amount that can be claimed for GPs via the ARRS (up to a maximum of the top of salaried GP pay range plus employment on costs) and enable PCNs to recruit a broader range of ARRS roles, where agreed with the commissioner.
41. We heard that stakeholders value the contribution ARRS staff make to expanding capacity and supporting modern general practice, and welcome the intention to provide greater flexibility in how the scheme operates. Some stakeholders expressed concerns about the distribution of GPs across practices within PCNs, the impact on continuity of care, and the importance of protecting the core practice-based workforce. In response, we are maintaining the proposal while ensuring the introduction of safeguards to protect additionality. At the same time, PCNs can of course agree to allocate ARRS funded GPs to individual practices within the PCN or restrict the number of practices they can work across. Our intention is to support sustainable

workforce growth, enable PCNs to recruit the mix of roles they need, and ensure that the scheme better reflects experience and local workforce needs.

General Practice Staff Survey

42. We will amend both the GP Contract Regulations and the Network Contract DES to require that practices and PCNs participate in the General Practice Staff Survey, including sharing staff contact details with their ICB so personalised survey links can be issued.
43. Overall, this proposal was well received from most stakeholders. We heard broad support for the principle of strengthening understanding of workforce experience across general practice, with stakeholders recognising the value of consistent and comparable insights to inform improvement. Some concerns were raised about how the survey results would be used and the importance of ensuring that participation does not create additional burden for practices. In response, we are maintaining the proposal while being clear that results are intended to support staff development and workforce planning rather than performance management of practices. Our intention is to build a comprehensive national picture of staff experience across practices and PCNs to inform policy and support a positive working environment.

Requirement for practices to engage with ICB support

44. We will amend the Regulations to require practices to engage with support from their ICB where unwarranted variation has been identified in contractor performance, including where practices are not meeting their requirement to see all clinically urgent patients on the same day, or where a practice is at risk of contractual breach.
45. Stakeholders recognised the value of consistent support arrangements, while also emphasising the need for this to be framed as improvement-focused rather than punitive. Feedback also highlighted the importance of clarity on unwarranted variation and how ICBs will fulfil their responsibilities in offering support. In response, we are maintaining the proposal while ensuring that supporting guidance will set out clear expectations for both practices and ICBs. Our intention is to promote early, collaborative engagement where challenges arise, helping practices access support in a timely and fair way.

PCN and neighbourhood alignment

46. We will amend the Network Contract DES to require PCNs to work collaboratively with their ICB to achieve greater alignment between the PCN registered list and the neighbourhood, where an ICB, working with the Local

Authority, defines a neighbourhood around a natural community that does not match current PCN geography. This change is not intended to signal widespread reconfiguration of PCNs. It is expected to apply only in limited circumstances and is designed as a pragmatic safety net where existing arrangements clearly do not reflect local communities.

47. We heard that while stakeholders recognise the importance of organising services around natural communities, they also raised concerns about the need to safeguard local relationships and the importance of clear expectations. Feedback emphasised that any changes to PCN geography must be manageable and informed by local circumstances. In response, we are maintaining the proposal while ensuring that supporting guidance will clarify intent, emphasise engagement with local partners, and provide assurances that changes should be implemented smoothly and proportionately. Our aim is to support better integration of services around neighbourhoods while retaining stability for practices and communities. Alignment with neighbourhoods would be based on coherent, practical geographies that minimise disruption to existing local arrangements.

Amending PMS regulations to align with GMS on sub-contracting

48. We will amend the PMS Regulations to mirror the GMS Regulations to give commissioners equivalent powers to object to sub-contracting arrangements where patient safety, financial risk or delivery of contractual obligations may be affected. Supporting guidance will be issued to clarify expectations.

49. We heard that stakeholders broadly supported ensuring greater consistency across contract types. Some sought clarity on how the proposed powers would work in practice and emphasised the importance of transparency for practices and patients. In response, we are maintaining the proposal while committing to provide clear supporting guidance for commissioners and practices. This will enable alignment of PMS arrangements with GMS, strengthen assurance mechanisms, and make sub-contracting expectations clearer and more consistent across the system.

Displaying opening times for all access modes

50. We will amend the Regulations to require practices to display opening times for all modes of access (walk-in, telephone and online consultation) on their website, in their practice leaflet and within practice premises. As a minimum this must be core hours for all modes of access.

51. We heard broad support for providing clearer, more accessible information for patients on how to contact their practice. Some stakeholders asked for

reassurance that the requirement would be proportionate and would not duplicate existing information that practices already publish. In response, we are maintaining the proposal while ensuring that supporting guidance will clarify expectations for implementation. Our intention is to improve transparency for patients across all access routes, support clearer communication, and ensure consistent presentation of information without placing unnecessary burden on practices.

Annex B – Summary of GPCE proposals and DHSC/NHSE responses

This annex summarises the proposals put forward by GPCE for the 2026-27 GP contract and sets out the DHSC and NHSE response to each. The responses reflect careful consideration of GPCE's representations alongside wider stakeholder views, affordability, and deliverability within the 2026/27 contract framework, while noting where issues raised will continue to inform future work on GMS reform.

1. Safeguarding and collaborative arrangements DES

GPCE proposed replacing the current patchwork of Local Enhanced Services with a comprehensive, nationally agreed and fully funded service. This would include coverage for medical reports requested by probation services and fostering agencies.

The issues raised by GPCE reflect wider concerns about fragmentation, funding responsibility and workload associated with safeguarding-related activity. While this proposal cannot be taken forward in the 2026/27 contract, it raises important questions about consistency and resourcing that are more appropriately considered as part of the broader programme of GMS reform.

2. Online access safeguards

GPCE called for urgent national safeguards to support safe online access, including engagement with online consultation providers, a national OPEL style framework for general practice pressures, patient-facing guidance on appropriate use of services, and flexibilities for practices facing exceptional demand.

Work is already under way with online consultation providers to improve functionality and safety. There are already a number of effective local OPEL frameworks and tools in place across primary care systems, and systems are expected to monitor demand, capacity and pressures, and we will consider whether there is scope to further explore a more consistent national approach outside of the GP contract. We also recognise the importance of clear patient-facing communication and will explore working with stakeholders, including GPCE, to improve messaging on appropriate use of general practice services. Separately, we are proceeding with contractual changes to ensure parity across access routes, including preventing capping of online consultation requests.

3. Clinical Negligence Scheme for General Practice (CNSGP) – information governance

GPCE proposed extending the CNSGP to explicitly cover liabilities arising from data protection breaches and patient records management, reflecting practices' role as data controllers.

We recognise the importance of clarity and assurance around indemnity in this area. DHSC and NHSE will explore the feasibility and potential costs of extending CNSGP

coverage with NHS Resolution. However, any changes would require further consideration and cannot be implemented for the 2026/27 contract year.

4. Joint GP IT Committee (JGPIT) and GP Connect

GPCE raised concerns about risks associated with the implementation of GP Connect Update Record functionality and sought assurances around governance, safety and assurance processes.

Further to the points raised, NHS England has considered the remaining issues and is taking forward a number of actions. The position set out below reflects current arrangements and planned next steps, alongside clarification already provided on matters such as the GP Connect information model.

Editorial Policy & Information Model - We already have an established information model and editorial approach in place. However, we are reviewing and strengthening these elements, including clearer articulation of the rationale for coded data and continued alignment with SNOMED CT principles. This will also include ensuring our maintenance cycle and governance arrangements remain transparent and robust.

Hazard Assessment - A hazard assessment was undertaken as part of the original development work. We are now updating the hazard log to reflect recent learning and to ensure all contributory factors and mitigations are fully captured.

Assurance Framework - We have a clear assurance process in place for GP Connect Update Record, and pharmacy suppliers will shortly be operating under the DSIC framework, which provides an even more rigorous level of assurance. We will ensure our documented processes reflect these arrangements, including expectations around skills, testing and data quality.

Pregnancy Coding Issue - The lessons learned exercise is largely complete, and we are collating these into a final report. GPCE and RCGP will be engaged as appropriate once the report is finalised so that key learning can be shared through the appropriate clinical channels.

For future programmes of similar scale and impact, we propose establishing time-limited working groups with appropriate representation, including GPCE and RCGP, to support structured engagement and assurance.

5. Restoring resourcing for general practice

GPCE called for a significant increase to the global sum payment per weighted patient, proposing an uplift of £50 per patient per year in 2026/27.

The Government has agreed a funding settlement for 2026/27 that delivers a £485m uplift to the GP contract, bringing total investment to £13,863m. This represents a 3.6% cash increase and includes provision for pay assumptions and other cost pressures, which will be revisited in light of pay review bodies' recommendations.

While this does not meet the scale of increase proposed by GPCE, it reflects the available funding settlement.

6. Uplifting SFE payments and item of service fees

GPCE proposed uplifts across SFE payments and fees in line with inflation, expanded locum reimbursement arrangements - and improvements to sickness, parental leave and suspension payments.

For 2026/27, we propose to uplift the following elements of the SFE by 2.5%, with the position to be reviewed following DDRB recommendations.

- payments for GP performers covering maternity, paternity, neonatal care, adoption leave and shared parental leave.
- payments for locums or GP performers covering sickness leave
- payments for locums to cover suspended doctors
- payments in respect of prolonged study leave

Routine childhood immunisation fees were uplifted in 2025/26, and the impact of further increases will need to be assessed before considering future changes to other item-of-service payments.

7. DDRB award uplift declaration

Sessional GPC proposed mandatory clauses to ensure DDRB uplifts are passed on to salaried GPs, alongside strengthened monitoring and declaration requirements.

These proposals raise complex issues around funding flows, enforcement and contractual responsibilities. They are not being taken forward through the 2026/27 contract but will be considered as part of wider GMS reform discussions.

8. GP premises funding and system reimbursements

GPCE sought a commitment to joint working to develop a new, funded approach to GP premises as part of contract reform.

While we recognise the importance of premises in supporting sustainable general practice, we are not able to commit to a new funded approach at this stage. The issues raised are better considered as part of longer-term GMS reform.

9. Practice-level GP employment support scheme

GPCE proposed a practice-level GP reimbursement scheme, potentially targeted by list size, recruitment challenges and demand.

We have taken this proposal forward. In response to feedback, including from GPCE, we will introduce a practice-level GP reimbursement scheme in 2026/27, supporting practices to increase GP capacity as the most sustainable route to improving access. The proposed detail of the scheme will be shared with GPCE via

an amendment to the SFE, and we welcome discussions on the proposed approach to implementing the scheme as it impacts on remuneration.

10. Partnership premium scheme

GPCE proposed introducing a partnership premium scheme in England, modelled on the Welsh approach.

This proposal is not being taken forward through the 2026/27 contract but will be considered as something to explore under future GMS reform work.

11. Early career GP fellowships

GPCE proposed a one-year early career GP fellowship to support recruitment and retention in hard-to-recruit areas.

NHS England remains committed to supporting retention in general practice, with increasing emphasis on local flexibility. ICBs now have greater autonomy to deploy workforce support in ways that best meet local needs.

12. GP partnership scheme

GPCE called for reinstatement of the “new to partnership” scheme.

The scheme was time-limited and was extended beyond the planned two years in recognition of pandemic impacts. DHSC and NHSE have no current plans to reintroduce it.

13. Targeted Enhanced Recruitment Scheme (TERS)

GPCE proposed reintroducing TERS to support recruitment in under-served areas.

Funding for TERS ended in 2025 following improvements in GP specialty training fill rates and limited evidence of long-term retention effects once training was completed. As such, the scheme is not being reintroduced.

14. ARRS GPs

GPCE proposed removing restrictions on ARRS GP eligibility, increasing reimbursement levels, limiting the number of practices an ARRS GP can work across, and reintroducing fellowship and retainer schemes.

The 2026/27 ARRS changes proposed by DHSC and NHSE address key elements of GPCE’s proposal by removing the restriction that funding can only be claimed for recently qualified GPs and increasing the maximum reimbursement amount that PCNs can claim for ARRS GPs. Decisions about whether ARRS GPs are embedded within a single practice or work across multiple practices remain a matter for PCNs and practices to agree locally.

These changes sit alongside a broader set of ARRS updates in 2026/27, including increased flexibility over the roles PCNs may recruit and deploy through the scheme, subject to local agreement.

We are grateful to GPCE for the depth and breadth of its engagement. While not all proposals could be taken forward within the 2026/27 contract, the issues raised provide important input into implementation planning and the ongoing programme of GMS reform, which will continue to be developed in dialogue with the profession.