Bundle 1 - Incentives and V&I

Access incentive scheme (PN004)

Summary

1. Repurposing of the money currently assigned to the PCN Capacity and Access Payment (£292m), to a new practice-level access incentive scheme.

GPCE Comments

2. We welcome the movement of funding from PCN DES into the core GMS contract. The movement of PCN funding into core GMS would, we believe, significantly increase its impact for practices and patients and remains LMC England conference policy.

3. In line with this we would also recommend looking at other pots of funding associated with the PCN DES that could be 're-patriated' to a practice level but where outcomes could be at a PCN or Neighbourhood level.

4. With regards to the proposed scheme itself, we have a number of concerns and questions with the proposal as outlined.

5. The precise impact of the proposed scheme in terms of both funding and workload will depend largely upon where the thresholds will be set, and how achievable they are for practices, bearing in mind that in the 12 months up to November 2025, 44% of appointments were same day, and 81% within 2 weeks. A significant proportion of the remaining 19% will be follow-up appointments that would not be suitable to be within a 14 day period.

6. There is significant concern that the data used for the scheme may be used by local commissioners as a form of practice performance management, with ICBs pushing to meet the 90% same day appointment target for 'clinically urgent' appointments, as set out within the NHS England Medium Term Planning Framework.

7. This, in combination with a number of the proposed contractual changes set out in 'Bundle 2', appears to represent a significant attempt to push general practice away from preventative medicine, chronic disease management and expert generalism, towards a focus to triage unlimited demand providing urgent care to mitigate activity at a Trust level, at the expense of routine care and long term continuity of care. This will further exacerbate inequalities, and serve to frustrate the Government's three national NHS priorities.

8. GP practices would need significant and concrete reassurance that the scheme would remain purely based around funding additional and optional incentives and not be utilised for performance.

9. Funding would be much better used to directly support increasing the practice-level GP workforce and appointment availability to improve access (see proposals for practice level workforce support programmes sent by the BMA in December 2025 in response to the 2026/27 GMS contract consultation) which would increase clinical capacity, help to increase patient access and satisfaction, and provide Government with a tangible 'win' in the eyes of the public. The Institute for Government's report in late 2025 set out that '*only the number of GP appointments delivered in a practice has a strong statistically significant relationship with patient satisfaction*'[1].

QOF (PN006)

Summary

10. Changes to QOF indicators, adding 18 points whilst reducing indicators from 44 to 43. Key changes cover diabetes checks, weight management and CVD related indicators

GPCE Comments

11. A summary of the primary concerns are set out below. We will provide full comments following the discussion on the 22nd Jan full comments.

Childhood vaccinations

12. The changes to account for MMRV are noted. However, we still have significant concerns with the ongoing impact of the lack of Personalised Care Adjustments (PCAs) in the childhood vaccination indicators. As raised in previous years, the current approach has a significant 'cliff edge' for payments. Practices with relatively small population list sizes could receive a very modest number of parental refusals to miss targets completely, regardless of what actions the practice takes to encourage participation. There is a continuing risk that this approach disincentivises practices from taking additional steps and effort to increase vaccination coverage if they feel

[1] https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england/appointments-satisfaction#:~:text=There%20are%20lots%20of%20reasons,appointments%20that%20a%20practice%20delivers

that there's nothing that they can do to persuade their registered patients otherwise.

Diabetes

DM037

13. The proposed indicator is worth only 10 points with the expectation of checking 8 indicators (BMI/BP/HbA1c/lipids/smoking status/foot exam/A:Cr/eGFR) instead of one (the diabetic foot examination).

14. Whilst some indicators may be coded elsewhere, (A:Cr for DM006; BP for DM036; HbA1c for DM020/21 and lipids for DM034/35) recording a smoking status and eGFR is additional.

15. The indicator should include PCAs, specifically for A:Cr as some patients will not be appropriate (due to long term urinary catheterisation, urinary/faecal incontinence etc).

16. This could stand to impact many locally commissioned services which seek to target the 8 care processes, especially in those populations serving deprived T2DM populations with many other co-morbidities whose funding may not reflect the clinical complexity and prevalence of their caseload.

Obesity Management

OB004

17. The allocation of five QOF points (circa (£1,250 total) for weight management referral in place of £11.50 per referral under the weight management Enhanced Service could result in a significant funding drop. For example, a practice referring 300 patents would see an income drop from £3,500.00 at present. In addition, we require clarification as to which programmes this would cover, and what happens if such programmes are not available or not accessible on a local basis?

OB005

18. A QOF incentive for Tirzepatide, would mean ICBs are likely to cease any locally commissioned services for this (which in some areas is proving to be very effective and a lever for neighbourhood working.)

19. A potential solution to this would be to use this QOF indicator to incentivise ongoing treatment of Tirzepatide for weight management once the dosage

has been titrated and stabilised within general practice, and to develop a separate DES for the initiation, monitoring and titration within the first year. (The BMA guidance on Tirzepatide highlights the monitoring requirements in the first year).

Cardiovascular Disease Prevention

H009

20. Collating the 4 pillars management approach to congestive heart failure (ACE/BB/MRA/SGLT2) into only 12 QOF points represents a significant workload shift and large transfer of workload from secondary care into general practice without equivalent or adequate resource, especially considering ongoing significant issues in the commissioning and delivery of HF services locally. This approach further disincentivises ICBs from contract managing acute Trusts appropriately; commissioning appropriate specialist HF clinics; and local commissioning/resourcing of HF services and outcomes from local general practice.

21. The risk for this proposal (and for OB005) is that patients will be subject to a postcode lottery at best, and widening existing inequalities and a deleterious patient experience more generally at worst, because the funding for GPs will not be commensurate with the workload.

Expansion of RSV cohort (PN010)

Summary

22. Expansion of the RSV vaccination programme to cover all registered patients who are a resident of a Care Home for Older Adults and all their registered patients aged 80 and over who have not previously been vaccinated. This is in line with the recommendations of the Joint Committee of Vaccination and Immunisation (JCVI).

GPCE Comments

23. The expansion is noted but we wish to draw attention to the potential workload implications which must be considered. We would request further information on expected cohort sizes and expected workload increase for practices.

Vaccinations in care homes (PCN) (PN014)

Summary

24. Ensure covid and flu vaccinations in care homes, requiring this to be offered if the PCN is delivering covid and flu vaccinations generally, facilitating another offer if no PCN practices are delivering, and introducing an explicit requirement for PCNs to identify outstanding vaccinations in care homes and ensure they are delivered

GPCE Comments

25. The broad public health objective is noted; however this potentially represents a significant workload increase.

26. Certain elements remain unclear: for example, if only one member practice signs up to deliver Covid vaccinations, is the expectation that the requirement relies on that one practice to ensure full care home coverage? Or is it on the PCN as a whole? If the latter, given the move of Covid vaccinations to a practice-level, how will funding for these vaccinations flow to the practices?

Advice and Guidance Enhanced Service (PN016)

Summary

27. Withdrawal of the A&G Enhanced service to be replaced by a contractual requirement "to continue prioritising the use of A&G prior to, or in place of, a planned care referral where clinically appropriate and to adhere to local referral pathways, such as 'Single Point of Access' once introduced", with £82 million funding put into Global Sum. Systems would ensure that all referrals are subject to appropriate specialty-level clinical triage, delivered via a single point of access (SPoA).

GPCE Comments

28. Shifting funding into the Global Sum moves this identified activity into a capitated contract at a fixed sum reflecting no expectation of increasing this activity and uplifting it below CPI. It also risks exacerbating existing inequalities by it now being subject to Carr-Hill formula weighting. Pre-weighting the current level of proposed funding would equate to

approximately £13,000 per practice, with actual funding levels varying based on respective Carr-Hill weighting.

29. Transferring this additional service into a contractual requirement within the Global Sum would also mean that the funding going into the contract must be adequate to cover any additional activity required. To this end, there is no modelling provided within the current proposal to inform the expected level of activity that this change would mandate.

30. Practices and GPs **must** retain the absolute right to make referrals into specialist services when clinically necessary. The utilisation of A&G pathways must not be a pre-condition to making such a referral. Any such move would represent a significant shift in activity from secondary care to general practice with a default position that increasing amounts of care is effectively moved into GP without commensurate resource.

31. Taking such an approach result in more patients having to wait longer to access specialist treatment, with general practice effectively managing the risk of holding secondary care waiting lists, without adequate resource to do so and with unlimited liability.

32. Further information and discussion is required about the proposed SPoA before this may be implemented. Contractual requirements for compliance with a process not yet in place, and with little to zero detail, must not be enacted.

33. It is unclear from the proposal if there will be any commensurate changes to the NHS Standard Contract, contract management and commissioning processes to reduce the current unwarranted variation in approach from Systems and Trusts. NHSE must protect practices from exacerbating existing local commissioning gaps and shifting priorities and policies in the opposite direction to the Government's national objectives.

Bundle 2 – Core Contract

Sharing data with the Lung Cancer Screening Programme (PN007)

Summary

34. Requirement practices to share cohorting data (SNOMED codes of current and former smokers) with the national lung screening programme

GPCE Comments

35. Whilst support of the programme in principle is a given, we have experienced a number of related issues in practice and likewise recognised by committee members and LMCs nationwide which arise from sharing such data, that need to be taken into consideration.

36. Alongside its main purpose, the screening flags non-lung cancer related health issues e.g. arterial calcification. These are flagged to the GP which then results in unresourced workload to further investigate, refer and manage these patients to aim to prevent cardiovascular events.

37. Introducing the proposed contractual requirement therefore requires the provision of additional support for practices in dealing with such sequelae, and the need to ensure that there are adequate services and necessary timely secondary care capacity available locally for such subsequent referrals and onward specialist care.

General Practice staff survey (PN011)

Summary

38. Requirement for practices to participate in the NHS staff survey, (in years that the survey is run and funded nationally.

GPCE Comments

39. We have serious concerns with regard to this proposal.

40. General practices are independent businesses and as such it is unclear from the proposal as to how the results of the survey will be used to support practices and their staff. Further information on deployment and utilisation of the survey for practices is required.

41. Will the results be used as part of a wider national/local picture? Will practices have access to survey results for their own practices, in order to help inform their planning and staff development? If so, how will anonymity and confidentiality of responses be ensured given the small team size in general practice compared with the thousands of staff employed by hospital trusts?

GP registration & catchment area (PN012)

Summary

42. Changes to the GP registration system to streamline the GP registration process and formalise arrangements for recording practice boundaries.

GPCE Comments

43. With regards to the registration proposal, we foresee that this may be problematic. There is limited ability for practices to check whether patients actually reside in the practice area. Practices thus require a commensurate mechanism to enable a check of appropriate registration, ideally in an automated manner, in order to avoid a situation where the practice has to subsequently contact a patient, to advise they are not entitled to register with the practice. We also have concerns around safeguarding; potential perpetrators of abuse and those with drug-seeking behaviour will risk misuse of such a proposal. This requires a risk and impact assessment with Police and the Named GP Safeguarding Network.

Ensuring patient choice of pharmacy (PN013)

Summary

44. A contractual requirement that patient choice must be supported for referrals and triage to pharmacies, with patients able to choose from a full list

GPCE Comments

45. The principle of the proposal belies concerns that the mechanism as proposed would result in a significant increase in workload. This suggests a bureaucratic step which will be required in excess of hundreds of millions of times per annum with each consultation which generates an FP10.

46. We need evidence to demonstrate what tangible improvements will be created rather than an increase in bureaucracy before we could fully support this change.

47. 365 million consultations took place in 2024/25. Assuming 50% may have generated an FP10, and assuming such a step may take 5 seconds, this would add an additional bureaucratic burden equivalent to almost 29 years of time across the year.

Dedicated GP email address for communication with community pharmacy (PN015)

Summary

48. Requirement for parties to have a dedicated email address for communication with community pharmacy, as a failsafe if GP Connect fails.

GPCE Comments

49. There is a potential that could result in work duplication if this proposal is not properly implemented, which could cause increased administration workload and increase risk of drug error. It may make more sense to link in community pharmacies to clinical pharmacists within the PCN.

Requirement for GP Practices to collaborate with ICB Support (PN018)

Summary

50. Requirement for GP Practices to collaborate with ICB support, replicating the current expectation to collaborate before closing practice lists to cover where there is 'unwarranted variation' or 'practice being at risk of contractual breach'.

GPCE Comments

51. We have strong concerns that this will be utilised by ICBs as a punitive measure, against practices who may not acquiesce to the demands or interpretations of the local ICB. In 2019 the PCN DES set out how the commissioner would work with the LMC to find how to come to a reasonable arrangement with the contractor to settle concerns around PCN geographies, memberships, and collaborative working. We would support the continuation of that principle.

52. There needs to be commensurate national requirements upon ICBs with regards to what support they should be providing to local practices, to assist in reducing variability between areas and any potential for embedded inequalities which may create tension but be beyond the control of any party.

53. Any such measure has to be part of a wider a package of support for practices and not be dependent upon the discretion of the local commissioner.

54. We require significant further detail on examples and implementation. If the proposal is for support, then this needs to be set out explicitly.

GP practice cannot ask a patient to call back on a different day (PN019) and Requirement for same day access to GP practice where it is clinically urgent (PN020)

Summary

55. Contractual requirement that a GP practice cannot ask a patient to call back on a different day. This would replace the current wording that says 'an appropriate response must be provided in same care hours period'.

56. An explicit requirement that clinically urgent requests (as defined by the clinical judgment of a GP) must be dealt with on the same day.

GPCE Comments

57. Without seeing the proposed alternative wording, we are unable to assess the potential impact of this change. We would be interested to know if this is considered to be a widespread issue that needs to be addressed via contractual change, or if amendments are being proposed in order to address a minority of incidents that would be better handled via normal contractual management processes.

58. As with the proposed Access Incentive Scheme, these proposals appear to put the focus of general practice upon the delivery of urgent care, prioritising this over planned, preventative and continuity of care. Such a unilateral step permanently alters the very nature of our specialty and we are not able to support this, primarily in the interests of patient safety given the paucity of capacity and resource.

59. The clear movement over recent years to constrain practices' autonomy in managing their capacity: demand has significantly reduced their ability to manage to continue to provide a safe service without diverting resources to focus upon providing immediate access over protecting continuity of care and the delivery of routine care to patients. Practices are losing their ability to autonomously manage planned care. Whilst this is no doubt seen as desirable by NHSE, it is leading to increasing patient harm and moral injury to GPs and practice teams. We cannot support this.

60. It must be recognised that clinical (and administrative) capacity in general practice from 08:00 – 18:30 Monday – Friday is a finite resource which must be deployed in the manner that best suits the needs of the registered list of patients and the practice. Where significant investment in general practice to increase this capacity is not forthcoming, practices will be forced to ration resources. This will exacerbate the novel yet increasingly common phenomenon of waiting lists to see a GP.

61. It is not clear what exactly constitutes 'clinically urgent' or how the commissioner expects to monitor or verify implementation of such a requirement. We have profound concerns that this may lead to the introduction of further requirements to serve its purpose.

62. There is a lack of clarity as to how a complex clinical situation may be handled where there is potential disagreement over the urgency of a presentation (e.g. NHS 111 dispositions may classify cases as urgent when they may be safely routine. This creates frustration for GPs and patients alike).

63. GPs have a clinical and professional duty to their patients. Where possible, we would expect cases presenting as urgent to be treated as such where this is possible. Determining this via a regulatory approach appears to be primarily focused upon policing outliers, but we could foresee this as a tool to potentially penalise practices and protect Emergency Departments at all costs, even if this means risking the continuity of general practices and the wellbeing of GPs and their practice teams.

Sub-contracting of services (PN021)

Summary

64. Aligning PMS and GMS regulations allowing commissioners to object to subcontracting of clinical matters if there is patient safety risk or an inability to meet obligations.

GPCE Comments

65. There has been a general move to greater alignment of PMS and GMS over recent years, and it is noted that this would be an extension of that movement.

66. We believe the existing GMS regulations are very clear, in allowing commissioners to object to a subcontracting arrangement on the grounds of patient safety, and material financial loss to the commissioner.

67. We do not see what is to be gained with additional guidance to assist the enforcement of the provisions by commissioners, as proposed other than to pressure ICBs into reneging on 'shoulder' agreements in place for over twenty years between practices and local OOHOs, which we would not support changing where this arrangement has been extant.

Amend the GP contract Regulations to clarify that capping online consultation contacts in core hours is not permitted (PN022)

Summary

68. Adding an explicit reference to the Regulations, that in addition to the online consultation system being switched on for the duration of core hours, GP practices must not cap the number of requests which can be submitted through it.

GPCE Comments

69. GPCE notes the key findings from NHSE's HSSIB regarding how online tools were not always easy for patients or staff to use and didn't always capture the right information needed for safe decision-making. HSSIB gave examples where online tools contributed to missed or delayed care. Safety may be under-recognised or under-reported especially if services are overwhelmed. Online request tool design often does not involve patient or staff input**,** meaning systems may not be fit for users' actual needs.

70. We recognise that the HSSIB doesn't regulate policy but advises improvements**.** However, their recommendations include that NHS England should evaluate the patient safety risks of online request tools in general practice, considering patient and staff experiences, and that NHSE should support general practices better in procuring and implementing such online tools safely.

71. While digital access and online tools have a role in modernising access to care, they must be implemented and supported in ways that don't disadvantage patients who struggle with digital access, which involve patient and staff insight in design, that ensure clinicians are trained and confident in using them and which protect patient safety and support alternative access routes where needed.

72. GPCEs position remains that agreement and implementation of further safeguards are more necessary than ever, including:

- Engaging with online tool providers to find pragmatic solutions that work for patients and practitioners; ensuring software providers are not mandated to override the wishes of their users (GPs) and impose technical limitations or unsafe platforms
- Agreement of a national OPEL protocol to inform local, system, and national pressures with subsequent practical support offered to practices giving parity to general practice as experienced by other system partners
- Patient-facing advice from Government around reasonable and appropriate use of finite resource within general practice
- **Flexibilities in allowing practices to take steps to prioritise patent safety if or when they become overwhelmed by exceptional pressures on a working day, threatening the delivery of safe care, whilst surgery reception desks remain open**

73. Practices must be allowed the flexibility, capability and trust to manage demand in the way necessary to maintain clinical services and that fulfils

their contractual commitment to meeting the reasonable needs of their patients.

74. Limiting this will see practices focusing their limited resources into demand management rather than clinical treatment which will ultimately harm patient care.

75. We have already seen significant number of examples of misuse of online consultation systems since the widespread implementation from 1 October 2025; practices are left with too few tools with which to manage this.

Opening times for all modes of access to be displayed on practice website and surgery signs (PN023)

Summary

76. Update Regulations to make explicit that patients can expect:

a) that opening times information should be provided for phone line and online consultation availability in addition to walk-in, and
b) that this information should also be displayed in the surgery in addition to on the practice website and in the practice leaflet and
c) that the hours displayed for all modes of access must be at least the core hours period.

GPCE Comments

77. The proposed requirement seems needless and potentially problematic. Core hours of operation are already defined within the GMS Regulations. Furthermore, under the Regulations a practice may subcontract the delivery of clinical matters, provided that it is reasonable in the circumstances to do so; that the proposed subcontractor is qualified and competent to provide the service; and prior written notification is given to the ICB of the intention to subcontract.

78. This may include the subcontracting of services within core hours, providing that the requirements as set out within the regulations are met, and that the Commissioner does not see any grounds that would put patient safety at risk or put the commissioner at risk of material financial loss.

79. It would appear that this requirement therefore conflicts with this.

Timely access to data to support monitoring, including access (PN024)

Summary

80. Amendment of the GMS and PMS regs to enable NHS England to contractually require GP practices to provide data and information in relation to online consultation and video consultation services.

GPCE Comments

81. Developing this data may be helpful in order to more fully demonstrate the levels of demand within general practices, and consequently the levels of resource required, but the same was said of cloud-based telephony systems in 2023/2024 and we have seen these used primarily for performance management. We believe that this will be the same, and we cannot agree to this.

82. We have already seen case studies of such data being utilised for performance management at a local or national level to publicly attack, rather than support, practices. Prior to any further discussion we will need concrete reassurances over the use of such data and how this is permissible if enacted unilaterally when the partnership remains the data controller for the practice.

Bundle 3 – PCN DES

The Additional Roles Reimbursement Scheme (PN003)

Summary

a) Removal of the restriction that ARRS funding can only be claimed for GPs appointed within 2 years post CCT.
b) Increase of the maximum reimbursement amount for GPs. PCNs will be able to claim reimbursement for GPs up to a maximum of the top of salaried GP pay range (£114,743) plus employment on costs.
c) Increase in flexibility to allow PCNs to also recruit non-direct patient care roles from within the ARRS sum, subject to commissioner agreement.

GPCE Comments

83. We welcome the removal of restrictions and lifting of the reimbursable amount.

84. GPC England and the UK Sessional GP Committee maintain that the scheme would be significantly more impactful moving the funding used to develop and implement a practice-level employment support scheme. We continue to have concerns with the way that the current GP ARRS system operates, which these changes do not address.

85. These concerns, and our proposals to resolve them, are set out in detail within our previously submitted paper. For reference, they include:

- The real-life impact of working across multiple surgeries and multiple geographies across a PCN, meaning that such GPs often cover up to as many as 10 separate practices. This goes against continuity of care and the ethos of general practice. This is particularly detrimental to newly qualified GPs in particular, who need stability and increasing experience in continuity of care, working for one practice registered list. For example, with access to a mentor within their practice to support their transition from GP training to their new role.

- Lack of workload protections for ARRS GPs, meaning they often face unsafe workloads, lone-working and a lack of peer support leading to leaving NHS GP roles or mitigating exposure to them.

- Lack of a clear pathway to transition such GPs to permanent practice-based roles, meaning significant uncertainty over future employment and potential unemployment when the ARRS role comes to an end.

86. It is disappointing that other recruitment and retention schemes have been deprioritised. The New to Practice Fellowship scheme remained extremely popular among newly qualified GPs, but was scrapped in 2023/24.

87. The 2016 GP Retainer scheme keeps those at risk of leaving the profession in work, and supports them to transition into permanent, sustainable roles. We have heard anecdotally that access to the GP Retainer scheme is varied between areas: some ICBs utilise the scheme well, while others significantly restrict the number of roles available, or do not use the funding at all.

88. The underutilisation of the GP Retainer scheme means that GPs who could benefit from the scheme are more likely to leave the NHS completely, due to being unable to find similarly flexible roles.[2] There is also an inequalities element to the reduction in use of the GP Retainer scheme, as historically those who accessed the scheme often had protected characteristics or caring responsibilities.

89. As per our submitted paper, we therefore propose:

In the short term:

- Replace ARRS funding for newly qualified GPs with ring-fenced funding for practices to directly employ salaried GPs.
- Focus funding on deprived and rural areas, so under-doctored areas benefit the most.
- Restrict the number of practices that ARRS GPs can work across to up to a maximum of three, to improve continuity of care for patients and provide stability for ARRS GPs.
- Reintroduce the New to Practice Fellowship and reinforce the GP Retainer scheme nationally to open up more opportunities for sessional GPs.

In the long term:

- PCNs to work with practices to determine which are in greatest need of additional GP capacity
- Realise the potential for 1 FTE GP : 1,000 patients ratio by 2040, as outlined in the Patients First manifesto.

[2] The Retainer GP scheme was originally designed to support GPs with caring responsibilities to stay in the workforce by working a low number of sessions, with the intention of increasing sessions over time.

- Remunerate these GPs appropriately to make the GP career pathway as attractive as the consultant career pathway. Ensure that pay recognises the level of qualifications, experience, and the wide-ranging role of the expert generalist.

Continuity of Care (PN005)

Summary

90. Make the existing CAIP incentive on risk stratification a core requirement for PCNs.

GPCE Comments

91. Making this an unfunded requirement seems less about continuity of care, and more identifying patients who would benefit from additional care, whilst protecting acute trusts. This appears to be a step to enable other system 'reforms' to happen, rather than any genuine desire to improve patient continuity of care.

92. We have questions on what would be expected following the stratification process.

93. Provision of the additional care identified for these cohorts depends upon resources being made available, including ensuring that there are adequate services commissioned locally. The proposal as written does not set out what next steps should be, or how such patients will be supported.

94. We would question whether this is a reasonable core expectation of PCNs without the additional funding that the CAIP provided, or whether it is the best approach to improving continuity of care for patients, which is best done by GPs in local GP practices who know their patients, rather than via attempts from 'at-scale' service provision.

Amending cancer requirements in the PCN DES (PN008)

Summary

95. Expansion of the current wording to provide further clarity for PCNs on what they are expected to deliver.

GPCE Comments

96. The proposals appear to be clinically reasonable - however, they may represent a significant workload increase for PCNs and their member practices, with no commensurate increase in resourcing.

97. Additionally, they will require that the 'partners' reference in the proposed wording (including screening commissioning teams and providers) have the capacity and willingness to support PCNs in these endeavours. This may vary significantly from region to region, depending upon local commissioning.

98. We would therefore be keen to know further detail on what the new requirements are expected to actual entail for PCNs.

Vaccines and Immunisations – amending the Mandatory Network Contract Amendment (PN009)

Summary

99. Proposal to enable practices to voluntarily collaborate for flu and COVID-19 vaccinations under the Network Contract DES

GPCE Comments

100. Feedback has been provided previously via the Flu/Covid specification discussions.

Requirement in PCN DES for PCNs to cooperate with ICBs and others regarding neighbourhoods (PN017)

Summary

101. 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.

GPCE Comments

102. Implementation of PCN groupings and geographies following the implementation of the PCN DES in 2019 took a great deal of effort and

negotiation, including practices, LMCs, local commissioners, GPCE, and NHS England

103. This was done in recognition that a 'one size fits all' approach would not work, and the need to account for local geographies, demographics and communities. It is therefore concerning that this seems to place a lot of expectation on PCNs to fall in line with other providers and organisations, regardless of existing PCN operating structures or local relationships.

104. If neighbourhood services are to be genuinely built around general practice, then the existing needs, function and services of general practice within a locality must be recognised as the foundation. It is unclear from the proposal how such alignment will be defined or measured, and we have significant concerns over the disruption that enforced changes to existing PCN geographies will have on PCNs, practices and patient services, especially with no identified support or resource to help implement such change.

105. We have strong concerns that this will be utilised by ICBs as a punitive measure, against practices who may not acquiesce to the demands or interpretations of the local ICB. In 2019 the PCN DES set out how the commissioner would work with the LMC to find how to come to a reasonable arrangement with the contractor to settle concerns around PCN geographies, memberships, and collaborative working. We would support the continuation of that principle.

106. There needs to be commensurate national requirements upon ICBs with regards to what support they should be providing to local practices, to assist in reducing variability between areas and any potential for embedded inequalities which may create tension but be beyond the control of any party.

107. Any such measure has to be part of a wider a package of support for practices and not be dependent upon the discretion of the local commissioner.

108. We require significant further detail on examples and implementation. If the proposal is for support, then this needs to be set out explicitly.