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Primary Care Networks: Network Contract DES 2026/27

Detailed update on the 2026/27 PCN DES changes, access implications, ARRS flexibility, vaccination requirements, continuity expectations and immediate operational actions for practices and PCNs.

Styled revised edition: refreshed to match the updated QOF briefing style and corrected where wording needed tightening against the 2026/27 contract and DES guidance.

£ 485m	£ 292m	30 Apr
total GP contract uplift	repurposed into a practice-level GP reimbursement scheme	deadline for changes, opt-ins and opt-outs

Executive summary

The 2026/27 DES keeps the broad PCN structure in place, but changes the operating model in several important ways: GP workforce funding is more flexible, continuity of care is more explicit, care home vaccination duties broaden, cancer and screening responsibilities tighten, and participation in the General Practice Staff Survey becomes mandatory.

The most material shift is workforce-related. ARRS is no longer restricted to recently qualified GPs, the maximum reimbursement has increased materially, and the previous PCN-level Capacity and Access Support Payment and Capacity and Access Improvement Payment have been replaced by a new practice-level GP reimbursement scheme funded by £292 million.

At the same time, access expectations are clearer. Practices are expected to deal with requests identified as clinically urgent on the same day, cannot ask patients to call back another day, and online consultation systems must not cap requests during core hours. Operational data on access will matter more in 2026/27, not less.

What is in and what has gone

Removed or retired from 2026/27	New or newly explicit from April 2026
Capacity and Access Support Payment (CASP)	Practice-level GP reimbursement scheme funded by the repurposed £ 292 million
Capacity and Access Improvement Payment (CAIP)	Risk-stratification for continuity of care as a core DES expectation
Restriction limiting GP ARRS recruitment to recently qualified GPs	Explicit care home vaccination identification and offer requirement
Exclusion on collaborative adult flu and COVID delivery under the DES	Mandatory GP Staff Survey participation for practices and PCNs
Weight Management Enhanced Service	Stronger cancer referral, safety-netting and screening uptake requirements
Advice and Guidance Enhanced Service as a separate enhanced service route	PCN and neighbourhood alignment conversations in limited cases where geography does not reflect local communities

ARRS changes: GP recruitment is materially more flexible

The previous rule that ARRS funding could only be claimed for recently qualified GPs has been removed. In 2026/27, any GP can be eligible provided they have not been substantively employed as a General Medical Practitioner in a Core Network Practice of the PCN at any point in the previous 12 months.

The reimbursement ceiling has increased sharply. The salary element of the maximum reimbursement rises from £82,418 in 2025/26 to £118,759 in 2026/27, or £120,921 in London. Including employer on-costs, the annual equivalent maximum reimbursement reaches £152,900 outside London and £155,698 in London.

PCNs can also recruit a broader range of ARRS roles where agreed with the commissioner, including other non-direct patient care roles. Minimum role requirements have also been updated for Social Prescribing Link Workers, Physician Associates, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists, Paramedics and Advanced Nurse Practitioners.

ARRS GP change	2025/26	2026/27
Eligibility	Recently qualified GPs only	Any eligible GP not substantively employed by a core practice in the PCN in the previous 12 months
Maximum salary reimbursement	£82,418	£118,759 outside London / £120,921 in London
Maximum reimbursement incl. on-costs	Lower prior ceiling	£152,900 outside London / £155,698 in London
Other ARRS roles	More constrained role set	Broader range possible with commissioner agreement

Capacity and Access Payment 2026/27: what practices need to do

Sense-check correction: the funding move is confirmed, but the detailed mechanics of the new practice-level scheme were not fully published in the core DES documents at launch. Practices should distinguish carefully between what is confirmed nationally and what still depends on later implementation detail.

The old Capacity and Access Support Payment and Capacity and Access Improvement Payment are being removed from the Network Contract DES. In their place, NHS England is introducing a practice-level GP reimbursement scheme funded by the same £ 292 million.

The stated purpose is clear: practices use the money to recruit additional GPs or increase sessions from GPs already working in the practice in order to strengthen clinically urgent same-day access. This is not generic funding. It is targeted GP capacity funding tied to access.

What is confirmed	What is still unclear
£292 million moves from PCN-level CAP into a practice-level GP reimbursement scheme	The exact distribution formula for individual practices
Funding is intended for new GP recruitment or additional GP sessions	Per-session reimbursement rates and any local claims mechanics
The policy focus is clinically urgent same-day access	Any practice-level cap or allocation ceiling

What is confirmed	What is still unclear
Practices will be measured on access-related data	Whether locums or all sessional models qualify in the same way
GPs already employed through this funding can transfer to the new scheme	Whether every ICB will apply a separate route for well-staffed practices

The five access metrics now matter

Practice-level data collection will focus on five practical indicators that tell NHS England how access is working on the ground. Even where payment is not explicitly tied to a threshold today, these metrics should be treated seriously because they are highly likely to inform future oversight, contract development and intervention.

Access metric	Why it matters operationally
Call waiting time between 8am and 10am	Measures how the practice handles the highest demand period of the day
Call waiting time during core hours	Shows whether access pressure is a peak-only issue or a full-day issue
Percentage of clinically urgent patients dealt with on the same day	Directly reflects compliance with the new same-day access expectation
Percentage of non-clinically urgent patients dealt with within one week	Shows whether routine access still flows while urgent demand is prioritised
Percentage of non-clinically urgent patients dealt with within two weeks	Indicates whether backlog or capacity slippage is building under the surface

Three access rules practices should treat as live from day one

Same-day urgent response **Requests identified by the practice as clinically urgent must be dealt with on the same day.**	**No call-backs tomorrow** **Practices must not ask patients to call back or make contact on another day.**	**No online caps in core hours** **Online consultation systems must not cap the number of requests submitted during core hours.**

The rules leave the determination of clinical urgency to the practice. That is sensible clinically, but it also means practices need a consistent local definition from day one. Otherwise the same-day access data will be noisy, hard to compare and difficult to defend.

The phrase 'dealt with' is broader than 'seen face to face'. In operational terms it may include triage, remote clinical contact, advice and a clear management decision as well as an appointment, but each practice should document what it means within its own access model.

Continuity, care homes, vaccinations and screening

Sense-check correction: the vaccination duty is to ensure eligible aligned care home residents are identified and offered vaccination through workable arrangements. Delivery does not have to be by the PCN itself in every case, but the offer pathway must be real and coordinated.

Continuity of care is now more explicit. PCNs are expected to use digital risk-stratification tools to identify and prioritise patients who would most benefit from continuity of care, with named GP continuity where appropriate. This should be treated as a real operating requirement, not just a policy aspiration.

Care home responsibilities are broader too. PCNs must ensure that eligible aligned care home residents are identified and offered seasonal and routine vaccinations in line with national guidance. Delivery can be by the practice, the PCN or another provider, but a joined-up plan must exist.

Collaborative delivery of adult influenza and COVID-19 vaccination is now permitted under the DES, but vaccine governance is tighter. The previous grouping concept that enabled informal sharing of vaccines no longer applies, so network agreement wording and payment flows need to be explicit and lawful.

The contract changes also extend RSV to all people aged 80 and over and to all care home residents. Practices and PCNs should review how this interacts with care home pathways and local operational responsibility.

Cancer and non-cancer screening requirements are stronger and clearer. Referral quality should align with NICE NG12, electronic safety-netting is now very much expected, and PCNs have clearer duties to support uptake across breast, cervical, bowel, lung and other screening programmes.

Participation, governance and payment mechanics

Participation continues automatically for previously approved PCNs with no membership or information changes. Changes, opt-ins and opt-outs must be notified to commissioners by 30 April 2026.

The General Practice Staff Survey is now mandatory for practices and PCNs. This includes sharing staff contact details with the ICB so personalised links can be issued.

PCNs are also required to work with their ICB to better align PCN lists with neighbourhood boundaries in limited cases where current geography clearly does not reflect local communities. This is not intended to trigger widespread reorganisation, but awkward local footprints should assume the conversation is now live.

On ARRS mechanics, monthly claims continue to matter. Claims must be submitted through the designated online portal, relevant registration numbers must be included where applicable, and claims continue to be paid monthly in arrears subject to the additionality rules and the PCN's overall reimbursement sum.

Immediate actions

For PCN clinical directors	For practice managers
Rework the 2026/27 GP workforce plan across ARRS and the new practice-level GP reimbursement route.	Document the practice definition of clinically urgent need and how same-day handling will work in reality.
Make risk-stratified continuity of care a documented operational model rather than a policy aspiration.	Check telephony reporting, online consultation settings and whether any request caps still exist during core hours.
Confirm care home vaccination pathways and any collaborative flu or COVID delivery arrangements.	Decide early whether new funding is best used to recruit a GP, buy extra sessions or combine both routes.
Review whether neighbourhood alignment could become a live issue with the ICB.	Confirm readiness for the GP Staff Survey and ensure the contact-data handoff to the ICB is understood.
Check ARRS governance against the wider GP eligibility rules and updated role requirements.	Do not miss the 30 April 2026 commissioner deadline for any PCN changes, opt-ins or opt-outs.

Bottom line: The 2026/27 DES gives general practice and PCNs more room to deploy GP workforce funding sensibly, but it also raises the bar on access, continuity, vaccination governance and operational delivery. The best-prepared organisations will be the ones that treat the new funding flexibilities and the new access expectations as one linked agenda rather than two separate workstreams.